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REMARKS ON SOME FUNDAMENTAL PRINCIPLES IN OTO-RHINO-LARYNGOLOGY OF INTEREST IN GENERAL PRACTICE.[1]

By B. HILLER,
Hobart.

SOME years ago I was called in to attend a very profuse epistaxis in a man prominent in the engineering profession. As a first-aid measure, he had in his distress thought that he would apply the principles of hydraulics to the emergency. He reasoned that, if the air pressure in his nose could be made greater than his blood pressure, blood must cease escaping from the ruptured vessel. He accordingly performed what is known as Valsalva's experiment of inflating the middle ear—namely, he closed both nostrils between finger and thumb and made continuous forced expiration with his mouth closed. He very soon learned to regret his efforts, for he immediately felt deaf; on examination, a hæmato-tympanum was found on both sides—that is, both middle ears had become filled with blood forced there by way of the naso-pharynx and Eustachian tubes. Next day an acute suppurative *otitis media* of both sides developed, infection having been carried there from the naso-pharynx by the blood, and incision of both drums became necessary.

Reflection on this case called my attention to the fact that if one carefully delves into the ætiology of pathological conditions of the ear, nose and throat, many can ultimately be ascribed to erroneous but common practices, which have been evolved during the passage of time.

One of the greatest curses, so far as our ears and noses are concerned, is the practice of violent blowing of the nose (or even blowing it at all), especially in the presence of a coryzal or other nasal infection—a faculty which has been acquired only by humans. After all, the natural channel for disposal of nasal secretions is backwards into the naso-pharynx, and not forwards.

If a tiny drop of dilute solution of an aniline dye is lodged at any point on the walls of the nasal fossæ, excepting in the vestibules, it will soon be seen to have travelled, not anteriorly, but posteriorly to the posterior choana and into the naso-pharynx. This is brought about by the movement of the cilia of the ciliated columnar epithelium, which always produces a current in that direction.

By the forcible expulsion of the secretions anteriorly by way of the anterior nares (and the expulsion need not be very violent), a positive pressure is created within the nose and naso-pharynx, whereas a negative pressure obtained by "hawking" would be by far the more desirable, although for æsthetic reasons this can, of course, not be advocated. If, therefore, the nose must be blown, the action should be a gentle one and certainly without compression of the anterior nares.

The more one questions patients on the subject, the more one becomes convinced that by far the great majority of acute middle ear conditions in adults are precipitated in a similar manner to the case that I have just related, by forcible nose-blowing in the presence of one or other of the various nasal or naso-pharyngeal infections, whatever the nature of these may be, the infected secretions being driven up the Eustachian tube into the tympanum. In fact, I feel that if it were practicable for us not to blow our noses at all, acute suppurative *otitis media* in adults would probably be almost, but not quite, eliminated.

To a lesser degree these remarks apply also to children, although in their case the presence of adenoids with superimposed naso-pharyngeal infection is probably the most potent determining factor.

Unquestionably, also, this violent attention to nasal hygiene results directly in the development of acute sinusitis by the propulsion of infective nasal discharge through the ostia into the cavity of the sinuses.

With regard to those who are too young to abuse their noses and ears in this manner—that is, infants—the dorsal recumbent position whilst feeding is a common cause of acute middle ear suppuration. Especially when bottle-fed, and perhaps even whilst at the breast, the baby is often placed on his back in a horizontal position. If you compare

[1] Read at a meeting of the Tasmanian Branch of the British Medical Association on August 11, 1942.

the anatomy of the Eustachian tube of an infant with that of an adult, you will find that in the infant the tube is shorter and of larger lumen and runs a much more horizontal course from the naso-pharynx to the tympanum than in an adult. You will then readily realize how easily milk, vomitus, pus or infected mucus can pass along that tube into the middle ear and perhaps into the mastoid antrum. It thus follows that an infant should never be fed whilst in the horizontal position, and between feeds he should have his head propped up on at least one pillow, especially if he is lying on his back for any length of time. Yet many mothers "harden their infants" by refusing them a pillow at all! In addition, it is advisable always to keep the head end of the cot raised a few inches. It will, of course, be realized that these measures are of extreme importance for those infants suffering from respiratory or alimentary infections, because of the ease with which infected material may otherwise pass along the Eustachian tube.

Thus, the commonest determining cause of acute middle ear suppuration in adults and children on the one hand, and in infants on the other, is to a great extent preventible. The importance of this in the case of infants is further emphasized by the recent investigations of P. W. Leathart, of Liverpool. Leathart drew attention to the frequency of death due to infantile mastoiditis undiagnosed during life. He showed that the vast majority of deaths of infants aged under one year in England and Wales were certified as being due to the following air-borne or food-borne infections: bronchopneumonia, lobar pneumonia, acute bronchitis and gastro-enteritis. And of all these children, probably at least 60% would have been found, if they had been examined *post mortem*, to have undiagnosed mastoiditis. Further, if in all cases a diagnosis was made and treatment was given, the total infantile mortality from all causes would be reduced by almost one-half. Although in Australia the percentage may not be quite so high, it is probably nevertheless a not inconsiderable figure.

The old idea of waiting for the drum to rupture in the case of acute suppurative *otitis media* has long been discarded as unsafe, and even more so is that of waiting to operate on a patient suffering from acute mastoiditis until its presence is proclaimed by the development of a post-auricular swelling. The suppurative process can extend intracranially almost as readily. On the other hand, mastoid tenderness during the first few days of an acute middle ear suppuration does not necessarily indicate acute mastoiditis. This tenderness is present in the early stages in a great number of cases and is known as "mastoidism". It is due to acute inflammatory extension from the middle ear to the mucosa lining the mastoid antrum and cells, but not involving bony tissue proper. In the consideration of the anatomy of the part, it must be recognized that, at any rate in most cases, there must be at least some extension of infection into the mastoid antrum and cells. True mastoidism disappears after a few days, but if tenderness persists or develops later, involvement of bone—that is, true mastoiditis—is indicated.

The fundamental causes of the increasing prevalence of upper respiratory infections in modern man are still obscure; but the question is probably, at least to some extent, one of diet and general mode of living. Over-consumption of carbohydrates with possible vitamin deficiencies (*A* and *D*) and perhaps our indoor life are possible factors; but it seems certain that hypertrophy of adenoids and of tonsils often occurs in response to bacterial irritation and inflammation in coryzal attacks or specific fevers.

Man is said to be the only mammal capable of always breathing through the mouth, the nose being the instinctive route through which respiration takes place. A young infant almost invariably breathes wholly through his nose, and if one occludes that organ whilst he is asleep and he is thus forced to breathe through his mouth, he experiences some difficulty and immediately wakes up. In the case of a new-born infant with obstruction (atresia) of the post-nasal orifices—fortunately an exceedingly rare occurrence—the child lies at rest for a moment with his lips drawn tightly together and his cheeks slightly indrawn. Then he begins to struggle for air and the face becomes suffused and cyanosed; the condition is relieved as he commences to cry. As soon as the discomfort is relieved through the mouth-breathing necessitated by crying, the child ceases to cry, and there follows a recurrence of the difficult breathing. The cycle is immediately suspended when the lower lip is pressed down so that mouth-breathing is permitted. It is only at the end of about a fortnight that he learns voluntarily to maintain mouth-breathing.

Mouth-breathing is therefore an acquired habit, and its effects may be seen in the typical "neglected adenoid syndrome". The enforced mouth-breathing results in arrested development of the maxillæ, leading to high-arched palate and consequent deviation of the *septum nasi*, narrow pinched nose and crowded teeth, which readily become carious. The sum total of results of these conditions are chronic hypertrophic rhinitis, liability to infected sinuses, prolonged coryzal attacks, Eustachian catarrh, *otitis media* (acute and chronic), and a tendency to respiratory infections (both upper and lower) and also to chest deformities, following instinctive efforts to breathe through the nose.

Whether or not the prevalent lay belief that the use of the rubber "dummy" has a place in the causation of adenoids is debatable; but whilst not advocating its use, one must concede that an infant during the process of deriving comfort from that instrument must perforce employ nasal respiration. If one is not available, certain it is that the child will find some substitute, perhaps less clean, the use of which must have the same evil results, if indeed there are any. It would therefore appear that an injustice is being done in condemning the comforter on the suspicion that it is a predisposing factor to the formation of adenoids.

Normal nasal breathing depends upon a normal nose, and a normal nose is impossible unless it is used for breathing. As we have just seen in the "neglected adenoid syndrome", upon nasal breathing depends the development of the antra and a normal upper jaw and normal teeth; and upon the teeth depends the proper mastication of food, its consequent digestion, and liability or otherwise to gastro-intestinal disturbances.

Apart from the presence of adenoids, the other major cause of lack of normal nasal breathing is internal obstruction in the nose caused chiefly by a deviated septum or by hypertrophied inferior turbinates, or by both.

During the past few centuries we have gone to increasingly great lengths in protecting ourselves against the cold and inclement weather conditions generally, and especially at this time of the year, in shutting ourselves up comfortably before a fire at night. Very well; but then why sleep out of doors in all weathers, on doing which some pride themselves? That, of course, would be quite natural if we always lived an open-air life, day and night. The turbinates, after being temporarily accustomed to a warmer atmosphere, are suddenly set the task of endeavouring to warm the excessively cold inspired air, and gradually hypertrophy, in a similar manner to the muscles of the classical blacksmith's right arm, so that nasal breathing becomes more and more difficult. Further, the recumbent position, especially when the head is not raised, is also a predisposing cause of passive congestion.

For the relief of intranasal congestion and swelling in acute nasal infections, the local use of ephedrine, adrenaline and other similar drugs, as well as of a multitude of proprietory preparations containing one or more of these, is widely prevalent and widely advocated, especially by the makers concerned. The deturgescent action of these drugs on the mucous membrane is, of course, due to their vasoconstrictor properties.

If we are treating acute arthritis, an infected wound, a furuncle on the arm or in fact any acute inflammatory condition anywhere in the body, is it not a fundamental principle that, if practicable, the circulation of the part should be increased by the application of moist heat, dry heat, radiant heat or medical diathermy? That is, an attempt is made to increase the hyperæmia, the cell nutrition and the migration of leucocytes. Then, why should an acute inflammatory condition of the nasal passages, such as coryza, be treated by the expulsion of blood from the area by means of vasoconstricting

deturgescents? Why should this site be the one exception in the body to the general rule? Surely this treatment is quite illogical. If it is correct in principle to produce vasoconstriction in inflammatory conditions of the nasal mucosa, then it should also be wrong treatment to apply heat to the inflammatory conditions elsewhere in the body; with this idea I am afraid no one will agree.

After all, an acute inflammation is the reaction produced in the tissues by an irritant, infective or otherwise, and is directed against that irritant. Therefore, rather than checking the inflammatory reaction by means of vasoconstrictors, our aim, if possible, should be to promote this state, which really is an effort to remove irritant products from the tissues.

Furthermore, a peculiarity of these vasoconstrictors is that their use is followed by a greater or lesser degree of reactionary swelling of the tissues, and therefore, not only is the coryzal attack prolonged, but also the subsequent swelling of the mucous membrane predisposes the patient to an acute inflammatory condition of one or more of the paranasal sinuses by obstructing the ostium (or ostia) and thus interfering with the normal drainage into the nose. These preparations certainly do give temporary relief in freeing the nasal airway, and it is to this property that their popularity may be attributed; but any consideration of other later and long-term effects is completely subordinated to that of the immediate, though but temporary, relief of nasal obstruction.

Inhalations are, of course, deturgescents too; but they come under a different category. The respiratory portion of the nasal cavity (the vestibule and the olfactory portion being excluded) is lined by columnar ciliated epithelium containing numerous goblet cells and pierced by the ducts of subjacent racemose glands, both serous and mucus-secreting. The mucous membrane readily swells under pathological conditions, often attaining five or six times the normal thickness. Inhalations stimulate the glands of the mucous membrane of the respiratory portion of the nasal cavity, causing hypersecretion. This drainage of fluids from the mucous membrane causes it to shrink, and at the same time toxins and inflammatory products are expelled into the nasal cavity. In other words, inhalations, by increasing the usual rhinorrhœa, stimulate and assist nature in the normal way to clear up the condition, whereas the vasoconstrictors decrease the discharge and the circulation of blood in the part, and so hinder the natural processes of recovery. The key to victory in all infective conditions surely is efficient drainage—in this case, drainage of the infected mucosa. But, to go one step further, it is also reasonable to assert that the same remarks apply to acutely infected paranasal sinuses, the drainage of which is interfered with by swelling of the mucous membrane at the entrance to, and in the vicinity of, their ostia. The diminution of this swelling is naturally of paramount importance in the treatment of these conditions. The steam given off with an inhalation is in itself of comparatively little value, and the temperature of the water used should not be more than about 140° F. (60° C.); at this temperature the vapour of the medicament is slowly and steadily emitted. If boiling water is used, not only does the patient's head become over-heated, but also the vapour is driven off in such concentration as to exceed the patient's tolerance, and moreover, the solution is then quickly rendered more or less inert. As a rough guide, water at 140° F. is such as can be just comfortably borne by the immersed hand.

The last point that I should like to bring before you is that of pre-operative medication with morphine. Morphine is widely administered by hypodermic injection in all branches of surgery about half an hour before the induction of general anæsthesia, for the purpose, it is said, of producing mental tranquillity for the induction stage and not for the purpose of analgesia. Yet we are told that chiefly only the analgesic property of morphine is at first obtained, and that the soporific effects are at their maximum in from one and a half to two hours after its injection. This is noticeable in the practice of surgery under local anæsthesia, and Dr. Chevalier Jackson, of Philadelphia, and Dr. C. E. Corlette, of Sydney, have always recommended the preliminary injection of morphine one and a half or two hours before operations under local anæsthesia. It would therefore appear that a similar pre-operative period of time could possibly with advantage be allowed in the case of injections of morphine before general anæsthesia, and at any rate such a suggestion may be worthy of trial.

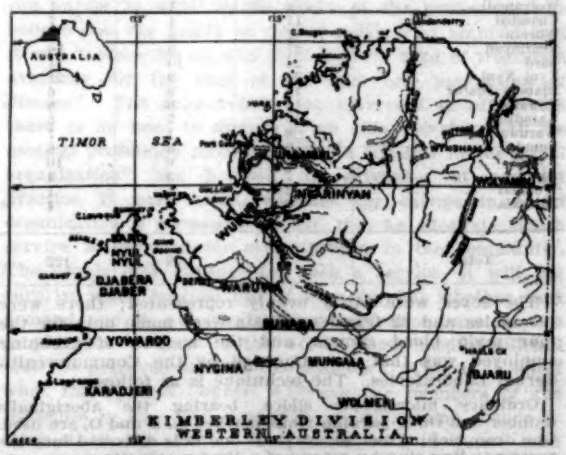
I hope you will pardon the somewhat discursive nature of this paper and the elementary principles enunciated in it; some of them, however, are of extreme importance in the prevention of morbidity, and of particular importance when applied to the prevention of deafness, the incidence of which in the community could certainly be lessened.

BLOOD GROUPING OF ABORIGINES OF NORTH-WEST AUSTRALIA.

By R. K. GAY, M.B., B.S., D.T.M.,
From the School of Public Health and Tropical Medicine, University of Sydney.

IN many parts of Australia it has been found that the pure-blooded aborigines belong exclusively to blood groups A(2) and O(4). No work in this field, however, had been done on the aborigines of north-west Australia, and it was thought that the determination of their blood groups might yield interesting and useful information. Accordingly blood was collected from pure-blooded members of most of the tribes at present existent in the Kimberley division of north-west Australia, and their blood groups were determined. The details and results of the investigation are set out in this report.

The Kimberley division of north-west Australia is roughly triangular in shape and is bounded on the west by the coastline, on the south by a line running due east from La Grange at the upper end of Ninety Mile Beach to Sturt's Creek, and on the east by a line running due north from Sturt's Creek to Wyndham on the Cambridge Gulf. Figure I shows the extent of the Kimberley division and the distribution of the tribes, from the members of which blood was obtained. This division is divided naturally into the following three parts: (i) the North Kimberley Area, consisting of the rugged mountainous country north of the King Leopold Ranges and west of the Cambridge Gulf and the Durack Ranges; (ii) the South Kimberley Area, comprising the Fitzroy Valley, Dampier Land and the hinterland of Broome and La Grange; (iii) the East Kimberley Area, which includes the Ord River Valley, Hall's Creek district and the desert country south of this as far as Sturt's Creek.



The North Kimberley Area, because of its rugged nature, has defied white settlement for years, and at present there are only three mission stations (Forrest River, Drysdale and Port George), one Government feeding station (Munja) and one cattle station in the whole area.

In most parts of the area the aborigines live in their wild state and are both dangerous and treacherous. They are of fine physique, and their numbers do not appear to have decreased to any extent during the last two generations. On the other hand, the South and East Kimberley Areas have been settled by white men for over fifty years, and Broome has served as the headquarters of the pearling industry since 1883. In both these areas the aborigines are of poor physique, and the usual degeneration and decrease in population, consequent on white settlement, have occurred, many tribes during the past two generations having become extinct. Little difficulty was experienced in obtaining blood from members of most of the tribes at present existent in the South and East Kimberley Areas. In the North Kimberley Area, however, it was possible to obtain blood only from the members of those tribes living at or near the mission stations.

Blood was taken from 201 pure-blooded aborigines, belonging to fifteen different tribes. Table I shows the tribes from which the aborigines came and the districts inhabited by those tribes.

TABLE I.[1]

Tribe.	District.
Wolyamidi	Wyndham.
Unambal	North-West Kimberley Area.
Wurura	Port George.
Ngarinyan	Munja Station.
Bard	Sunday Island. Cape Levique.
Nyul Nyul	Beagle Bay.
Djabera Djaber	Dampier Land.
Yowaroo	Broome.
Karadjeri	La Grange.
Waruwa	Derby Hinterland.
Bunaba	Fitzroy Crossing.
Nygina	Broome Hinterland.
Djaru	Hall's Creek district.
Mungala, Wolmeri	South-East Desert.

[1] The spelling of the tribal names, on which there is little agreement, is for the most part that used by Elkin.

Table II shows the number of aborigines from each tribe and the blood groups to which they belong.

TABLE II.

Tribe.	Number from Tribe.	Blood Groups.	
		A.	O.
Wolyamidi	2	1	1
Unambal	11	4	7
Wurura	17	8	9
Ngarinyan	27	9	18
Bard	24	10	14
Nyul Nyul	30	9	21
Djabera Djaber	15	9	6
Yowaroo	14	6	8
Karadjeri	13	7	6
Waruwa	8	1	7
Bunaba	9	3	6
Nygina	16	6	10
Djaru	7	3	4
Wolmeri	2	1	1
Mungala	6	2	4
Total	201	79	122

The sexes were fairly evenly represented; there were 109 males and 92 females. Tests were made only for the four main blood groups, and the method of grouping employed was that recommended by the Commonwealth Serum Laboratories. The technique is as follows:

Ordinary microscopic slides, bearing the aboriginal's number and three paraffin rings marked A, B and O, are used. One drop each of test serum A, B and O is delivered into the corresponding ring by means of a Pasteur pipette, a separate pipette being employed for each type of serum. One drop of corpuscular suspension, made by collecting a drop of capillary blood from either the finger or the lobe of the ear into three cubic centimetres of an isotonic solution consisting of 0·65% sodium chloride and 1% sodium citrate, is added to each ring, and the drops are thoroughly mixed by gentle rocking of the slide or by means of a match, a fresh match being used for each ring. Readings are made after ten minutes and a final check reading after thirty minutes.

In no case was it found necessary to employ a hand lens or a microscope for the reading, although both were frequently used as a double check. Other methods of grouping, including the agglutination tube method, were tried; but the one outlined above was found to be by far the most satisfactory, as regards both simplicity of technique and ease of interpretation. In no instance was any difficulty experienced in determining the group to which the blood belonged.

Results.

All blood examined was found to belong to either group A or group O. Of the 201 aborigines whose blood was examined, 79 or 39% were found to belong to group A, 122 or 61% to group O. There was no noticeable sex difference, 37% of the males belonging to group A and 63% to group O. Of the females, 41% belonged to group A and 59% to group O. The preponderance of group O over group A was maintained in all tribes with the exception of two, and in both of these the number of specimens of blood examined was too small to be significant.

Discussion.

These findings correspond with those of workers in other parts of Australia, inasmuch as all pure-blooded aborigines were found to belong to either group A or group O. They differ from the findings of Hackett and Johnston among aborigines of South Australia in the preponderance of group O over group A. Hackett and Johnston found that of 725 pure-blooded aborigines, 450 or 62% belonged to group A and 275 or 38% to group O—practically the reverse of our findings among aborigines of north-west Australia.

Summary.

1. Blood was collected from 201 pure-blooded aborigines, members of fifteen different tribes from the Kimberley division of north-west Australia.
2. All specimens of blood belonged to group A or group O, 39% to the former and 61% to the latter.
3. The percentages of aborigines in these two blood groups differ greatly in different parts of Australia.

Reviews.

WAR WOUNDS.

"THE PATHOLOGY AND TREATMENT OF WAR WOUNDS" is a collection of scientific papers dealing with this aspect of surgery published in various medical journals from 1915-1925.[1] In them we can trace the development of the advocacy of the physiological treatment of wounds both before and after actual infection has taken place. The story of the struggle between the chemical and physiological schools of treatment is well known, but it is of great importance to review it again in the light of our present knowledge. Wright saw the acceptance in the main of his views before the end of the last war and we now know that the common antiseptics are practically valueless in the treatment of infected wounds. The work contains much of interest, many ingenious experiments, such as one would expect from the author of the "Technique of the Teat and Capillary Glass Tube", are described, and although much of the subject matter is old and although some fallacies have since been discovered in some of the theories advanced therein, it still contains much of fundamental importance. Naturally one would like very much to hear from members of this school their opinion as to the nature and efficacy of the local treatment of infected wounds with the sulphanilamide drugs. All those interested in the general problem of antisepsis should particularly read the polemical paper at the end in which Wright answers and criticizes Cheyne's advocacy of antiseptics. This is a masterly exposition of the use of English and of the art of scientific controversy. The book is then still full of interest to all dealing with infections and can be read with profit by all such medical men.

[1] "Pathology and Treatment of War Wounds", by Sir Almroth E. Wright, M.D., F.R.S.; 1942. London: William Heinemann, Medical Books, Limited. Crown 4to, pp. 216 with illustrations. Price: 21s. net.

The Medical Journal of Australia

SATURDAY, NOVEMBER 14, 1942.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: Initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

THE MEETING OF THE FEDERAL COUNCIL.

After an interval of a little more than a year a meeting of the Federal Council of the British Medical Association in Australia has been held, and the report of the proceedings is published in the present issue. The items on the agenda paper of any Federal Council meeting cover such a wide field and are so bound up with every aspect of the life of medicine in Australia that only most exceptional circumstances justify the cancellation of a meeting. Ever since the outbreak of war a great deal of the time of Federal Council meetings has been devoted to discussion of matters connected directly and indirectly with the war effort. The matters under this heading with which the Council has had to deal during this year have been no fewer than in other war years, and it was most unfortunate that the first meeting for 1942 was to have been held at a time when conditions appeared to be particularly threatening for Australia. Most people will agree that in the circumstances the unanimous decision of the members of the Council to consent to a cancellation was fitting and wise. Between meetings of the Federal Council plenary powers are vested in the President. At ordinary times his duties are no sinecure, but during the twelve months that elapsed between the last two meetings the President's burden was heavy—he had to shoulder much responsibility and the demands on his time must have been great. No one who gives the matter a moment's thought can fail to appreciate service of this kind. The same sort of remark applies to other members of the Federal Council who attended the recent meeting. The best way in which members of the Branches can show appreciation of the efforts of those who serve the Association in this way is to give prompt and earnest consideration to matters referred to them by the Federal Council, not in any selfish or parochial spirit, but with minds intent on the honour and efficiency of the whole profession and the welfare of the whole people of the Commonwealth.

The subject which occupied most of the time of the recent meeting had to do with the future of medical practice. It was discussed under the heading of a general medical service for Australia, in connexion with the National Health and Medical Research Council and also in connexion with the details of a salaried medical service. These discussions must be viewed in their proper perspective. The perspective will perhaps be more easily gained if the discussion on the extension of contract practice is considered in the light of the document forwarded by the New South Wales Branch. This document showed that there is at the present time a demand by many persons for a nationalized medical service and it stated quite bluntly that the profession must be prepared to meet the position. Here is the key to the whole problem, or series of problems, if they are so regarded—"the profession must be prepared to meet the position". This should be taken as the medico-political text of the medical profession in Australia for, say, the next twelve months. What does preparation imply? It implies study. It does not mean the donning of blinkers by a person whose neck is so stiff from disuse that he can look only in one direction. If a problem is to be studied it must be approached with an open mind and from all sides. Its present implications must be discovered and its possible ramifications in the future estimated. Once the requirements, the needs, are known, the ability to meet them has to be gauged. This ability includes technical considerations, but also willingness to effort and audacity, qualities of heart and mind without which no real service to humanity is possible. The Federal Council at the instance of the New South Wales Branch has recognized the demand for the extension of contract practice; it has recognized a change in social organization as having created this demand. The change may or may not be temporary, but the Federal Council has agreed to the extension of contract practice on conditions which should be satisfactory to every one concerned.

As previously stated, the discussion on contract practice may help to create a perspective for the larger question of a general medical service to the people of Australia. There can surely be none in the ranks of the profession who believe that the health service of today is so planned that it will "ensure for all who need it every kind of treatment available for the cure of the sick and prevention of disease". The subject has been traversed so often that there is no need to discuss it on this occasion. If the medical profession recognizes that a "change in the social organization" has justified an extension of contract practice, it must insist, whether the change in social organization is permanent or not, that an adequate health service is provided for every person in the community. The people may clamour for such a service—it will not surprise many medical folk if they do—but whether they demand one or not, the medical profession must try to provide one—it must in the words of our medico-political text "be prepared to meet the position". This is in effect what the Federal Council will ask the members of the Branches to do. The time will probably come sooner or later when the medical profession will be faced with governmental proposals for a radical change in the conduct of medical practice. As the President of the Federal Council has stated, the profession will be in a hopeless position if at any discussions with the Government it has to reply "No" to a question of whether it has considered

a certain type of service. If the profession does not want a salaried service such as that drafted by the National Health and Medical Research Council, it must be prepared to say why. The Branches have already considered the scheme adopted by the Federal Council according to which payment would be on a *per capita* basis in respect of the treatment of certain persons whose incomes were below a stated amount. They are now to be asked to consider the scheme of the National Health and Medical Research Council and also the scheme of the subcommittee of the Victorian Branch Council and to send their comments and criticisms for discussion at the next meeting of the Federal Council. Nothing could be more reasonable than this. It gives the Branches a chance to try to achieve unanimity, and to provide data for the Federal Council if discussions have to take place with the Government at a later date.

This raises another point. Whatever its views may be, the profession must have only one mouthpiece when any discussions with a government have to take place. This mouthpiece must be the Federal Council, for it is the only body that represents the profession as a whole. The Royal Australasian College of Surgeons, the Federal Council was informed, has no wish to enter the field of medico-political discussion, but very properly intends to leave all such matters in the hands of the Federal Council. On the other hand the disturbing information was given that at least one prominent member of the Royal Australasian College of Physicians had taken steps to inform the Government on certain aspects of a salaried service. This is very much to be regretted. Although no fair-minded Government Minister would suppose for a moment that the opinions of a single individual could be taken as representing those of the whole profession, the views of one influential person at variance with those of the majority can do much harm. For this reason we welcome the proposed conference between the Federal Council and representatives of the Royal Colleges described in our report of the meeting. Finally, when the Federal Council is fully informed of the wishes of the Branches, it will be of great interest to see what happens when the medical profession consults with non-medical persons on the terms of the resolution carried on the motion of Dr. T. A. Price. If these conferences ever come to pass they may produce surprising results.

Current Comment.

SEMINAL CHANGES AFFECTING FERTILITY.

THE idea that an examination of the semen of the male partner is a necessary part of the investigation of the cause of female sterility seems to have been very slow in gaining anything like general recognition by the medical profession. There can be no doubt that in the past a great many fruitless surgical operations to correct harmless abnormalities have been performed on women for the want of such an examination and indeed of the means to carry it out. Of recent years, however, many studies of human male semen have been recorded in the medical literature, many gaps in our knowledge of the physiology and pathology of human spermatogenesis have been filled, and many clinics abroad have made good use of the information that has been gained. A demonstration by R. Mackey to a meeting of the New South Wales Branch of the British Medical Association at the Women's Hospital, Sydney, reported in this journal on November 15, 1941, is evidence of the advantage that is being taken of these recent advances in our knowledge in this country. Veterinary science, however, appears to have left medical science well behind in the study of male fertility. A knowledge of the factors affecting male fertility is, of course, of great importance to breeders of sheep, and therefore in this country, which derives so much of its wealth from this animal, the subject is one of national importance. Recently R. M. C. Gunn, of the Veterinary School, University of Sydney, has published some important studies in fertility in sheep, representing work which has been in progress for a number of years, and which would appear to be of great medical as well as of veterinary interest.[1]

These studies in fertility in sheep have been based largely on examination of the semen. The characters of the semen which have been studied include not only the morphology of the spermatozoa, but their motility, longevity and numbers and the hydrogen-ion concentration of the semen. The activity of the semen is related to both the motility and longevity of the spermatozoa and Gunn has devised a numerical means of expressing the proportion of motile spermatozoa in semen, their degree of motility and the duration of motility. This he calls the "activity number". The number of spermatozoa in each ejaculum is of importance because it has been found that high concentrations of spermatozoa are required for high fertility. Counting spermatozoa is very laborious and Gunn has found that an estimate of the numbers present may be derived from the appearance of the semen, which may be graded as "very thick creamy, thick creamy, creamy, thin creamy, thick milky, milky, cloudy and less than cloudy". The first-mentioned grade contains about 3,000,000,000 spermatozoa per mil and the last-mentioned less than 100,000,000. In case of doubt reference is made to the sedimentation which occurs after storage at 4° C. for two days in small tubes: semen which is "very thick creamy" or "thick creamy" sediments but little, one part of supernatant fluid to 100 parts of deposit; semen which is "creamy" or "thin creamy" sediments more—up to one part of fluid to ten of deposit—and so on. The hydrogen-ion concentration of the semen has been studied by Gunn only with litmus paper, but he has found that variations from its usual faint alkalinity or "amphoteric" reactivity are associated with abnormality of the spermatozoa. The morphological examinations made by Gunn were usually upon smears dried and stained in a standard manner: the semen was classified into several groups according to the percentage of disintegrated and other abnormal spermatozoa present.

Spermatogenesis in the ram was found by Gunn to be disordered by numerous commonly incident factors. A hot, dry season or a febrile illness greatly impaired the quality of the semen; in the early stages of a fever, however, the spermatozoa were found to be more numerous, more motile and more long-lived than normally. The assimilation of very small quantities of arsenic was found to cause appreciable seminal degeneration. Dietary deficiencies caused seminal degeneration also; as the result of numerous experiments it was found that vitamin *A* or its precursor, carotene, was a common deficiency of all the diets that produced seminal degeneration; night blindness was observed in all rams with degenerated semen and in most it occurred before the semen was affected. The addition of vitamin *A* or carotene to the diet resulted in restoration of normal spermatogenesis. A number of common disorders of the genitalia were found to be associated with impairment of spermatogenesis, namely, epididymitis with spermatocele, hypoplasia of the testis, large inguinal hernia and scrotal eczema, but not varicocele or cryptorchidism. Gunn considers that abnormalities of the genitalia detrimentally affecting spermatogenesis are those which interfere with the normal heat regulating function of the scrotum.

As to whether degenerative changes in the semen are associated with diminished fertility, Gunn has produced

[1] *The Australian Veterinary Journal*, June, 1942. (A short account of investigations reported fully in Bulletin Number 148 of the Council for Scientific and Industrial Research, 1942.)

some positive evidence from the experimental mating of rams whose semen characters were observed before, during and after mating and from stud and flock records. He draws the conclusion, amongst others, that the greater the degeneration of the semen the less the fertility.

These extensive researches are reported to have been put already to practical application by sheep breeders, who have been adopting times of mating and pasturing measures which are likely to bring about the maximum fertility of their rams. It is, of course, impossible to assume that the factors influencing spermatogenesis in man are identical with those which operate in the lower animals, but the studies to which we have alluded will indicate many lines upon which researches upon spermatogenesis in man might profitably be undertaken.

PREVENTIVE MEDICINE IN CHILE.

IN the issue of this journal for April 11, 1942, a special abstract was published of an article from the *International Labour Review* dealing with social medicine in Chile. This abstract dealt first with the economic and social background of the country; and under this heading the population, vital statistics and wages were described, and mention was also made of the departments of the Ministry of Health and the Ministry of Education. In a section devoted to the activities of the Ministry of Health mention was made of the *Preventive Medicine Act*. In the *International Labour Review* for August, 1942, the aims and achievements of this *Preventive Medicine Act* are discussed by Manuel de Viado, of the Social Insurance Department of the Chilean Ministry of Health. At the present time medical practitioners in Australia, as we have declared on other occasions, should seize every opportunity of gathering information on social reconstruction, wherever it is taking place, especially when it is directly concerned with preventive medicine. What is happening in Chile is therefore of importance to Australia.

Legislation in Chile in the sociological sphere is divided by de Viado into three stages. Before the year 1924 legislation was the result of individual effort; this was well-intentioned, but was lacking in technique and was largely foreign to the national character. Two important measures of this period are mentioned—*The Sunday Rest Act* of 1907 and the *Industrial Accidents Act* of 1916. From 1924 to 1933 the State showed an active interest; it attacked problems of labour organization and tried to deal with economic aspects of social welfare. Among the measures introduced were those dealing with compulsory insurance against sickness, invalidity and so on. In de Viado's opinion there was displayed during this period an excessive eagerness to undertake legislation without adequate preparation for the education of the masses in the principles involved and with no certainty that the necessary technical machinery would be forthcoming. This point should be impressed on any in this country who would allow their enthusiasm to run away with them. From 1933 onwards a strong nationalist sentiment has been displayed. In this "new phase" the experience of other countries has been adjusted to the national psychology, the State has taken a hand in insurance and a general health policy has been adopted which is "directed primarily at the protection of human capital". Characteristic of this phase is the predominant part played by medical benefit in social insurance. There is no reason, we are told, to be surprised at this phenomenon. The South American countries are largely rural and their economy is as a rule based on the exploitation of one or two agricultural or mining products; these countries are therefore "compelled to place medical and health problems in the foreground". The protection of the national manpower has become the watchword in every field of public welfare. In 1937 and 1938 the Maternity and Infant Welfare Service was set up and the *Preventive Medicine Act* was brought into operation; de Viado in the present article is concerned chiefly with the aims and achievements of the latter.

In Chile tuberculosis, venereal disease and cardio-vascular disease are jointly responsible for 60% of all deaths occurring during working life, for 56% of all hospital admissions, and for 38% of the "latent morbidity" in apparently healthy persons examined by the medical services of the insurance institutions. These diseases, and particularly tuberculosis, bring about an annual loss of 170 million hours of work (on a basis of an average of forty weeks' work a year per worker). In other words the loss is equivalent to the involuntary unemployment of one-quarter of the able-bodied population. De Viado holds that in young countries such as Chile, in contradistinction to the older countries of Europe (although there is no obvious reason why he makes the distinction) every medical policy must be based not only on action for the individual, but must go further and extend to the family and community as a whole. A sick man, in addition to attendance and medicine, should be given the economic means to support himself and his family during such time as he is prevented from doing so by illness. This statement is modified by the proviso that the community must not assume too heavy an economic burden. The three factors which require most consideration are: (*a*) the fight against those diseases which are collective in character and constitute a social danger; (*b*) special action against those forms of these diseases which are economically worth curing, effective treatment being possible; (*c*) the constant effort to turn the medical machinery and capital used to the best possible account. According to these ideas attention will be paid to the tuberculous patient rather than the diabetic, to secondary stage rather than tertiary stage syphilitics, "to the medical action of official institutions within the strict rules of controlled medical work, and not of private medicine, since treating one patient is not the same thing as treating a million". The features introduced for the first time by the new act are several: (i) Periodical medical examinations carried out systematically and free of charge for the great majority of workers and salaried employees of the country. (ii) The obligation of all social insurance institutions to set up medical services. This provision has supplied free medical service to about 150,000 salaried employees whose insurance did not previously provide such a service. (iii) The introduction of the system of preventive rest as an essential and effective means of saving the sick worker, treating him rapidly and prolonging his working life. A decision in this matter is made by special medical boards and rest is granted only to those likely to improve in health or recover. (iv) Payment during rest periods of an allowance equal to the full wage, the time limit being determined by the medical prospects of recovery. (v) Guarantee that the sick worker will retain his right to his post after recovery. (vi) "Extension of the concepts of collective, normative, planned and controlled medicine, under which submission to the prescribed treatment is compulsory and medical boards are set up to deal with any questions arising in this connexion." The operation of the act is financed by a levy of 2·5% on the gross income of the funds for medical expenses and by a contribution equal to 1% of wages, paid by employers and used solely for financing preventive rest allowances. Approximately 600,000 citizens or 10% of the population have been examined. The general morbidity rate is 19·6% of the persons examined. Allowances for "preventive rest" have been paid to 20,000 persons in all. Among the results of the introduction of the *Preventive Medicine Act* are (*a*) controlled treatment of many victims of syphilis, (*b*) action in regard to contacts with tuberculosis and syphilis, (*c*) mass radiography, (*d*) the provision of dental services at a low cost. In addition industrial medicine has been organized and a fresh impetus has been given to the study of occupational diseases.

This account of the working of the new act in Chile is interesting in that it gives an indication of what preventive medicine means when its main object is to benefit the State. This is all very well, but the human element seems largely to be lost. If social medicine is to achieve its object it must regard the individual first of all as a human being and then as a cog in the wheel of State.

Abstracts from Medical Literature.

PATHOLOGY.

Relation of Cardiac Lesions to the Clinical Course of Rheumatic Fever.

A. DALE CONSOLE (*Archives of Internal Medicine*, April, 1942) reports a series of 98 cases in which endocarditis or pericarditis, found at autopsy, had been preceded by a history of rheumatic fever with polyarthritis or other similar manifestations of disease. Aschoff bodies were found in all in which death occurred during the first decade of life, in 64% of those in which it occurred during the second decade and in 11% of those in which it occurred during a later decade. When Aschoff bodies were found in the myocardium (28 cases), the interval between the last attack of polyarthritis and death was with one exception five months or less. In three cases in which Aschoff bodies occurred in the myocardium there was no history of polyarthritis, chorea or other clinical evidence of acute rheumatic infection. A curve of the frequency of death in cases in which the symptoms of rheumatic fever and cardiac lesions occurred at different age periods shows two distinct peaks, one in the first decades of life, corresponding with deaths from cardiac failure and the presence of Aschoff bodies in the myocardium, and the other between the ages of forty and sixty years, associated with cardiac failure, deforming lesions of the valves and an absence of Aschoff bodies. Minor degrees of valvular deformity preponderated in the first three decades of life, whereas advanced deformity was common in the later decades. Valvular deformity increased with the duration of the disease after the onset of symptoms, but had no constant relation to the number of attacks or to the age at onset.

The Glomus Tumour.

THE glomus tumour, according to Margaret R. Murray and A. P. Stout (*The American Journal of Pathology*, March, 1942), is reputed to be an enlarged caricature of the highly specialized glomic arterio-venous anastomoses which have been found only in certain parts of the hands and feet at the cutaneous-subcutaneous junction. Is it really true, the authors ask, that glomus tumours occur elsewhere in the body, and if so how can this be explained? Are glomus tumours always small encapsulated neoplasms or do they over-display infiltrative growth or metastasize? What is the nature of the "epithelioid" cells which are so characteristic of the glomus tumours? Certain observations which have come to their attention enable them to answer the questions as follows: Glomus tumours can form not only in the cutaneous-subcutaneous zone of those parts of the body where no normal glomuses have been identified, but also in deeper tissues such as joint capsule and striated muscle. A glomus tumour which displayed progressive infiltrative growth has been described, indicating that not all of these tumours are localized and encapsulated. However, the authors do not believe that sufficient evidence exists to establish the fact of metastasis. The "epithelioid" cell of the glomus tumour has been identified as the pericyte of Zimmermann. Since this cell has been demonstrated in many parts of the body, this identification offers a satisfactory explanation for the occurrence of glomus tumours in those regions of the body where normal glomuses have never been found.

Non-Osteogenic Fibroma of Bone.

THE lesion which is the subject of a paper by Henry L. Jaffe and Louis Lichtenstein (*The American Journal of Pathology*, March, 1942) is being called "non-osteogenic fibroma of bone" because they hold it to be a benign tumour formed from matured marrow connective tissue and not containing osseous trabeculæ as an integral feature. In regard to the clinical findings, they note that most of the subjects are older children or adolescents and point out the lack of characteristic clinical manifestations in connexion with the disorder. They also note that the usual site of the lesion is the shaft of a long tubular bone (most commonly of a lower limb), not far from the nearer epiphyseal cartilage plate. It is observed that the lesion tends to be a small one and may not traverse the entire diameter of the affected bone, especially if the bone is not slender. Accordingly, it is remarked that the lesion may show up on radiological examination as a sharply delimited, eccentric, somewhat loculated area of rarefaction, hugging and even bulging out the cortex on one side or, on the other hand, as a multilocular area of rarefaction traversing the bone and even bulging it out on both sides. As to its pathology, the lesion is described as consisting grossly of several discrete but contiguous yellow-brown fibrous foci whose basic microscopic pattern is found to be made up of whorled bundles of spindle-shaped connective tissue cells loosely interspersed with small multinuclear giant cells, though, in some lesions, areas containing foam cells may also be present and even prominent. As to treatment, it is pointed out that thorough curettage or block resection of the affected area is all that is needed to abolish the disorder. Finally, the authors try to show why "non-osteogenic fibroma of bone" does not represent bone cyst (*osteitis fibrosa*) or giant cell tumour even in variant form, nor lipoid granulomatosis (Hand-Schüller-Christian's disease) in the form of a solitary lesion, nor a focus of "fibrous osteomyelitis".

Fibrous Dysplasia of Bone.

IN any individual case of the disorder of which Louis Lichtenstein and Henry L. Jaffe (*Archives of Pathology*, June, 1942) call fibrous dysplasia of bone, one, several or many bones may be implicated, and, especially in the cases in which the skeletal involvement is severe and has appeared early in life, certain extraskeletal abnormalities may also be present as part of the total disease picture. As to the skeletal aspect of the condition, emphasis is laid on the fact that when more than one bone is affected, the bones involved are likely to be solely or mainly on one side of the body. In an affected bone, the area implicated may be found expanded in part or throughout. Where it is not expanded, the regional cortex is likely to show at least erosion and thinning from the medullary side. The interior of the involved area is found to be filled mainly by an evenly whitish or reddishly speckled rubbery and compressible tissue. Fundamentally, this is fibrous connective tissue. It may be gritty throughout from the presence everywhere in it of newly formed trabeculæ of immature bone. Or, instead, it may show some smaller or larger, non-gritty, highly collagenous areas in which few if any bone trabeculæ are to be seen. In some lesions, islands of hyaline cartilage may also be present within the fibrous connective tissue. Furthermore, in an occasional lesion, focal degeneration of this tissue may have led to the formation of small secondary cysts. Altogether, the gross and microscopic skeletal features are quite adequate for clear delimitation of the condition. As to the extraskeletal aspects of the condition, it is pointed out that abnormal pigmentation of skin and (in females) premature sexual development are the two most common. Reference is also made of the presence, in a few instances, of hyperthyreoidism, ephemeral premature skeletal growth and maturation, and even a history of very grave icterus in early infancy. When the disease is regarded as a whole (skeletal and extraskeletal), much is seen to support the idea that it has its basis in a defect of development in which the central clinical picture, represented by the skeletal lesions, is amplified by the various extraskeletal abnormalities. As to the skeletal lesions in particular, these apparently result from perverted activity of the specific bone-forming mesenchyme, and the authors have attempted to suggest this derivation by the name "fibrous dysplasia of bone". The authors also devote attention to the clinical (including radiological) aspects of fibrous dysplasia of bone. The need for differentiation of severe fibrous dysplasia of bone from hyperparathyreoidism with severe skeletal involvement is also brought out. In addition, some broad rules for the management of fibrous dysplasia have been set down. Finally, it is pointed out that no cases of fibrous dysplasia of bone are known in which any of the lesions have undergone malignant transformation, irrespective of the extent of the skeletal involvement.

MORPHOLOGY.

Stimulation of Germinal Epithelium.

K. F. STHIN AND E. ALLEN (*Anatomical Record*, January, 1942) state that there is considerable evidence that the germinal epithelium of the ovary continues proliferation during adult reproductive life, and that some of the cells from these divisions contribute new ova and follicle cells. In the mouse there is some evidence that these proliferations are cyclical and that they are correlated in some way with other cyclical phenomena of reproductive activity. This has recently been confirmed for the guinea-pig. The cyclical nature of these proliferations suggests that they may be accentuated by certain specific stimuli and that normally these stimuli may be hormonal in nature. Since at each ovulation, *liquor folliculi* containing œstrogen must come into extensive contact with the surface epithelium of the ovary, especially in

animals which have a closed ovarian capsule, follicular hormone came first to mind as a possible stimulant. As shown by extensive experiments, its principal action is to produce growth in cells of the genital tract of the female. The study reported here records attempts at local stimulation of germinal epithelium in mice by the injection of œstrogen into the ovarian capsule. The authors find that mitotic proliferation of the germinal epithelium was stimulated both in normal hosts and in hosts which had been subjected to hypophysectomy.

Human Nervus Terminalis.

A. A. PEARSON (*Journal of Comparative Neurology*, August, 1941) states that the *ganglion terminale* is formed by the migration of cells and fibres from the medial border of the olfactory placode in the region of the *Anlage* of the vomero-nasal organ. These cells form groups along the medial border of the olfactory nerve. The migration of these cells continues until one end of the *ganglion terminale* lies in contact with the ventro-medial wall of the forebrain. There is some evidence that cells migrate from the forebrain into the *ganglion terminale*. This migration may explain the origin of the sympathetic ganglion cells in the *ganglion terminale*. With further development and differential growth, the *ganglion terminale* becomes separated from the forebrain. The connexion with the forebrain is retained by the fibre bundles which leave the caudal end of the ganglion and enter the forebrain in that region. The fibres of the *nervus terminalis* in young embryos pass to the ventral wall of the forebrain in a broad stream. In older embryos several nerve bundles may constitute the central roots of the *nervus terminalis*. These bundles course caudad from the *ganglion terminale* close along the medial border of the olfactory bulb and stalk. The roots of the *nervus terminalis* penetrate the ventro-medial surface of the forebrain just caudal to the attachment of the olfactory bulb. The larger and more medially placed bundles course in the brain close to the surface for some distance. Some of these fibres reach the septal region of the brain. The *nervus terminalis* is often differentially stained in pyridine silver preparations. This makes the course of the *nervus terminalis* distinct from that of other nerves in that region. From the rostral end of the *ganglion terminale*, a branch is given off which is distributed to the anterior region of the nasal septum. Some of its fibres are distributed to the epithelium of the septum. Bipolar ganglion cells migrate from this epithelium. Several nerve bundles leave the ventral border of the *ganglion terminale* and follow the branches of the vomero-nasal nerve. Ganglion cells are scattered along the course of all the peripheral branches of the *nervus terminalis*. Cells migrate also from the vomero-nasal organ. The consensus of opinion is that the *nervus terminalis* is functional in mammals and that there are sensory and autonomic components.

Development of Dentine.

G. BEVELANDER (*The Anatomical Record*, September, 1942) gives an account of the development and structure of the fibre system of dentine and presents several figures. The first discernible structure which can be related to the formation of dentine is a fibrous reticular membrane. This membrane is continuous with the fibres of the dental sac; it consists of a narrow band of delicate argyrophilic fibrils located on the periphery of the pulp and arranged parallel to the contour line of the tooth. Concurrently with the appearance of the odontoblasts, fibrils of the reticular membrane become radially arranged. Additional fibrils derived from the pulp are added to the first formed radial fibres which penetrate the odontoblast layer, after which they splay out and continue to the dentino-enamel junction. With the subsequent formation of additional dentine the fibres in the pulp retain their earlier relations; those in the dentine, however, undergo a rearrangement in direction and a decrease in affinity for stains.

The Pyramidal Tract in Man.

A. M. LASSEK (*Journal of Comparative Neurology*, April, 1942) states that there are approximately 688,800 myelinated fibres in the human pyramidal tract at the level just above the motor decussation; 89·57% are of small diameter (1μ to 4μ), 8·7% of intermediate calibre (5μ to 10μ) and 1·73% of large size (11μ to 22μ). Over one-half of the fibres are about 1μ thick. According to the theory that variations in the size of neurons (including the diameter of their nerve fibres) are associated with corresponding differences in nerve activity, the large fibres conducting impulses more rapidly than the small, only a small percentage therefore of pyramidal tract fibres are designed for speedy transmission of impulses. The pyramidal tract appears to be about 61% myelinated. The slow rate of myelination in the pyramidal tract may be explainable by the great number of smaller fibres present.

British Medical Association News.

MEETING OF THE FEDERAL COUNCIL.

A MEETING of the Federal Council of the British Medical Association in Australia was held at the Medical Society Hall, Albert Street, East Melbourne, on September 25, 26 and 27, 1942, SIR HENRY NEWLAND, the President, in the chair.

Representatives.

The following representatives of the Branches were present:

New South Wales: Dr. George Bell, O.B.E., and Dr. W. F. Simmons.

Queensland: Dr. T. A. Price and Dr. A. E. Lee (as substitute for Colonel D. G. Croll, C.B.E.).

South Australia: Sir Henry Newland, C.B.E., D.S.O., and Dr. A. F. Stokes.

Tasmania: Dr. C. Craig and Dr. J. S. Reid.

Victoria: Dr. F. L. Davies and Dr. H. C. Colville.

Western Australia: Dr. N. M. Cuthbert and Dr. F. W. Carter.

Minutes.

The minutes of the previous meeting of the Federal Council of September 22, 23 and 24, 1941, which had been circulated amongst members, were taken as read and signed as correct.

Postponement of Meeting Convened for February 27, 1942.

The General Secretary read correspondence which had passed between him and the President regarding the meeting of the Federal Council which had been convened for February 27, 1942, to be held in Melbourne. It was explained that in view of the urgency of the national situation at that time, the President thought that the meeting should be postponed. The General Secretary said that he had communicated by telegram with each of the members of the Federal Council and that the decision to adopt the President's suggestion had been unanimous.

Appointment of Office-Bearers.

Only one nomination for the office of President had been received, that of Sir Henry Newland, and he was therefore declared elected. Sir Henry Newland thanked the members for his reelection.

Only one nomination for the office of Vice-President had been received, that of Dr. George Bell. Dr. Bell was declared elected. Dr. Bell was also reelected as Honorary Treasurer of the Federal Council.

Annual Report of the Federal Council.

The annual report of the Federal Council for the year ended June 30, 1942, which had been circulated amongst members, was taken as read and received.

Finance.

Dr. George Bell presented the financial statement and balance sheet as at June 30, 1942. The statement, which included the Federal Council account and the Australasian Medical Congress (British Medical Association) fund account, was received. Dr. George Bell submitted a statement setting out the probable income and expenditure to December 31, 1942, and also for the year 1943. Some discussion took place in regard to a possible saving effected by the postponement of the February meeting. After full consideration, it was decided that the *per capita* payment from the Branches for the following year should be six shillings.

The Council also received the Federal National Health Insurance Emergency Account.

Priority in Air Travel.

The General Secretary read a letter from the Western Australian Branch dealing with the difficulties of air and

rail travel to and from the meeting, and Dr. F. W. Carter explained the difficulties which had to be overcome by the Western Australian representatives desirous of attending Federal Council meetings. He asked that special consideration might be given to these difficulties when arrangements were being made for the holding of future meetings. He expressed disappointment that a request from him for alteration in the date of the present meeting had not been granted. It was resolved that, in future, special consideration should be given to the travelling requirements of the Western Australian representatives.

Rulings on Branch Membership.

Correspondence was read from the Queensland and Western Australian Branches regarding the transfer of a member of the Association from one Branch to another. The Federal Council approved of replies which had been sent to the Branches by the General Secretary. It was pointed out that a Branch could not refuse to accept the transfer of a member from another Branch, even if, in the new Branch area, he proceeded to hold an appointment of which the Branch in that area could not approve. It was also explained that if a member was transferred from one Branch to another in the early months of the year, before he had paid his Branch subscription for that year, the Branch into whose area he moved had to accept him; and the subscription for that year, when paid, would be sent to the original Branch from which he had transferred.

A Broadcast Debate on the Nationalization of Medicine.

A letter was received from the Western Australian Branch in regard to some views expressed in a debate sponsored by the Australian Broadcasting Commission on the nationalization of medicine. It was pointed out that the views expressed were not official and that non-medical persons, many of whom opposed nationalization, were more concerned about them than members of the profession. The correspondence was received.

Neutral Doctors.

The General Secretary reported that he had received a letter from Dr. G. Morel, delegate in Australia and New Zealand of the International Red Cross Committee, asking for information regarding neutral doctors in Australia for appointment to the Mixed Medical Commission prescribed by the International Convention of 1929 on prisoners of war. The Secretary reported that he had communicated with the several Branches, but that no neutral doctors were available. The correspondence was received.

Dr. G. C. Anderson, C.B.E.

The General Secretary reported that he had written to Dr. G. C. Anderson, C.B.E., Secretary of the British Medical Association in London, congratulating him on behalf of the President and members of the Federal Council on the honour received by him from His Majesty the King, when His Majesty created him a Commander of the Most Excellent Order of the British Empire.

Decorations Received by Medical Officers of the Australian Armed Forces.

The General Secretary also reported that on behalf of the President and members of the Federal Council he had offered congratulations to the following medical officers of the Australian Armed Forces who had been honoured by His Majesty the King: Major-General S. R. Burston, C.B., C.B.E., D.S.O., V.D.; Colonel J. Steigrad, C.B.E.; Lieutenant-Colonel K. W. Starr, O.B.E.; Lieutenant-Colonel C. W. B. Littlejohn, O.B.E., M.C.; Lieutenant-Colonel A. L. Dawkins, O.B.E.; Captain A. Fryberg, M.B.E.; Major I. J. Wood, M.B.E.; Major J. O. Smith, M.B.E.; Captain S. J. M. Goulston, M.C.; Surgeon-Commander L. Lockwood, M.V.O., D.S.C.

Medical Officers' Relief Fund (Federal).

Dr. George Bell submitted the balance sheet and trustees' report of the Medical Officers' Relief Fund (Federal) as at June 30, 1942. He said that on the whole the condition of the fund was satisfactory. Of the outstanding loans, which amounted to £3,161, by far the greater part was good. He also pointed out that though the original fund amounted to only £12,000, there were nearly £10,000 in hand at the present time. In reply to questions by several members of the Federal Council, he said that the number of members subscribing to the original fund was relatively small. Only 419 members had contributed, and they were distributed as follows: New South Wales 182, Victoria 84, Queensland 75, South Australia 29, Western Australia 33, Tasmania 16. He suggested that several small loans should be cancelled, as the accounts were stationary and the debtors were at present on active service. This suggestion was adopted.

A Proposed Federal Medical War Relief Fund.

At the last meeting of the Federal Council consideration had been given to a previously mooted proposal for the establishment of a returned medical officers' relief fund. At that meeting it was resolved that the views of the Branches should be ascertained regarding the desirability of the establishment of such a fund and how it should be financed if its initiation was thought desirable. In the present instance the fund was referred to as a federal medical war relief fund. The General Secretary reported that he had written to the several Branches to ascertain their views. The Victorian Branch had replied that it was not desirable to establish such a fund at the present time. The Queensland Branch had expressed the view that such a fund was necessary, but thought that if a fund was created it should be administered in Queensland for Queensland beneficiaries, and asked whether the fund was to be voluntary or not. The Tasmanian Branch had thought that a fixed amount should be asked for. The South Australian Branch approved, but thought that the fund should not be for the present war alone, and the New South Wales Branch thought that the fund should be established at a later date, the present time not being opportune. On being written to again at a later date, the Queensland Branch had expressed the view that a federal medical relief fund should be established by means of an increase in Branch subscriptions. The Tasmanian Branch thought that the time was not opportune on account of the existence of so many other funds. The South Australian Branch had approved, but it expressed the opinion that assistance should be given to any member who was in distressed circumstances or injured as a result of enemy action. The Western Australian Branch had recognized the need and had said that it would help, but thought that the fund should not be extended to include general benevolence.

Dr. George Bell pointed out that there was some doubt as to what position such funds would be in at the end of the war. It had been stated in regard to a fund existing in New South Wales that at the end of the war any surplus would be taxed as income. The Western Australian representatives pointed out that they had been informed in their State that a relief fund with trustees to assist medical officers on their return to civil life would not be exempt from taxation at the end of the war. Dr. F. W. Carter thought that a legal opinion should be obtained by the Federal Council. Dr. George Bell also thought that the legal position should be clarified, and he moved that consideration of the matter should be deferred until this could be done. Dr. Bell's motion was seconded by Dr. N. M. Cuthbert and carried.

The Queensland representatives pointed out that they wished to have a general relief fund established. The General Secretary then raised the constitutional issue. He said that the funds of the Association could not be used for such a purpose. Before they could be so used, it would be necessary to alter the memorandum and articles of association.

Dr. C. Craig moved that a subcommittee should be appointed to consider a general scheme of medical relief, which would include all members of the Association irrespective of whether they were members of the armed forces or not. Dr. Craig's motion was seconded by Dr. A. E. Lee. Dr. T. A. Price objected to the use of the word "benevolence". He held that the fund should be a kind of insurance and that it should be independent of charity. If the constitution of the Association stood in the way of the establishment of such a fund, the constitution could be altered. Dr. H. C. Colville opposed the motion. He said that members of the Branches would not agree to an increase in their subscriptions, but would allow their membership to lapse. He thought that the discussion had gone a long way from medical war relief. The idea proposed was grandiose. Dr. A. F. Stokes supported Dr. Colville's views. A compulsory fund, such as had been described, would be difficult to establish in South Australia. Any fund that was raised should be voluntary. He also thought that the suggestion that medical practitioners should help one another was not benevolence. Dr. Craig pointed out that he was only asking for the appointment of a committee. The motion, on being put to the meeting, was lost.

A proposal by Dr. T. A. Price that Dr. Bell's motion should be rescinded was lost.

The Australasian Medical Publishing Company Limited.

At the meeting of the Federal Council in September, 1940, a discussion took place in regard to the Australasian Medical Publishing Company Limited and the supply to members of the Association of THE MEDICAL JOURNAL OF AUSTRALIA. As a result of this discussion it was recommended to the Branches that the Federal Council should make a legal agreement with the Australasian Medical Publishing Company Limited so that each member in the Commonwealth should receive THE MEDICAL JOURNAL OF AUSTRALIA. The matter was also discussed at the meeting of the Federal Council in March, 1941. It was resolved at that meeting that the Australasian Medical Publishing Company Limited should be asked whether it was willing to enter into an agreement with the Federal Council for the supply of the journal. It was also resolved that if an agreement was made, it should provide that every member of the Association in Australia should be supplied with THE MEDICAL JOURNAL OF AUSTRALIA and that the journal should be designated the official organ of the British Medical Association in Australia. Dr. George Bell and Dr. W. F. Simmons were appointed a committee to deal with the Australasian Medical Publishing Company Limited for the drawing up of an agreement. At the meeting of the Federal Council in September, 1941, a draft agreement was considered, and the altered agreement was sent to the Branch Councils for approval.

The General Secretary reported that he had sent a copy of the agreement to the directors of the company and to the Branches. The South Australian Branch had approved of the agreement. The New South Wales Branch and the Queensland Branch had also approved. The Western Australian Branch had approved of the agreement, but had referred to the method of election of directors of the company and to the right of veto held by the directors of the company. The Victorian Branch had amended the agreement in several respects and had sent draft copies of the agreement as amended by it. It was resolved that the Victorian amendments should be considered *seriatim*.

In the final agreement sent to the Branches by the Federal Council, the clause dealing with the appointment of an editor or editors contained a provision that no editor or editors should be appointed except after consultation with the Federal Council. Dr. H. C. Colville moved on behalf of the Victorian Branch that these words should be omitted. He explained that in the view of the Victorian Branch the agreement should be one between the Federal Council and the Australasian Medical Publishing Company Limited purely for the supply of the journal. The company had a journal to sell and the Branches wished to buy it. The Victorian Branch did not wish to interfere with the company in the control of the journal.

Dr. W. F. Simmons said that he thought that the Federal Council should have some control. He also added that the Federal Council should be aware of the position in which the Australasian Medical Publishing Company Limited found itself. The company consisted of eighteen members, three of whom were elected by each of the several Branches, and it was a fact that some of the members of the company were graduates of sixty years' standing and longer, and were not able to take an active part in the affairs of the company. He thought that members of the company should be appointed for a limited period.

Dr. T. A. Price thought that the words under discussion were necessary, and he pointed out that in his opinion they did not constitute a veto. Dr. Colville's motion, on being put to the meeting, was lost.

Dr. H. C. Colville moved the next amendment, which concerned the omission of the next clause. This clause had to do with the appointment of an editor and the submission to the Federal Council of evidence of the appointee's qualifications. It also laid down the procedure that should be adopted if the Federal Council should disapprove of a proposed appointment. This motion was lost.

Dr. H. C. Colville moved the omission of a paragraph which stated that the journal should be the official organ of the Federal Council of the British Medical Association in Australia, and that a statement to this effect should be printed in the journal. After some discussion on this point the President asked the Editor of THE MEDICAL JOURNAL OF AUSTRALIA whether he had any views to put before the Federal Council. The Editor spoke against the proposal. He expressed the opinion that the position of the journal would be stronger of it were not known as the official organ of the Federal Council. He referred to the freedom of the Press and to the necessity for any member to be able to discuss freely in the columns of the journal any matters dealing with the Federal Council or the Branches. If the journal was the official organ of the Federal Council, some responsibility would rest on the Council for views expressed in the editorial columns. In the Editor's opinion and in the opinion of his directors, the present position was entirely adequate. It was the Editor's custom in all matters affecting the Federal Council to consult with the President or the General Secretary, and in regard to any matters affecting Branches to consult with Branch Councils, and then to act as seemed most advisable. The directors of the company held that an editor had to be trusted, and that if he was not worthy of trust he should be removed from office. The Editor appealed to members of the Federal Council to delete the clause from the agreement. Dr. C. Craig said that he thought the Federal Council should be guided by the Editor's opinion. Dr. Colville's motion was carried.

Another paragraph in the draft agreement dealt with the period during which the agreement should operate. It stated that the agreement would continue for a period of ten years, and unless either party should give written notice to the other of its intention not to renew the agreement at least two years before its expiry the agreement should continue in operation for a further period of ten years. Dr. H. C. Colville expressed the view of the Victorian Branch that this period was too long, and it was resolved that the term five years should be substituted for ten years and one year for two years. The clause as amended stated that if neither party gave notice of its intention not to renew the agreement, then the agreement should continue in operation for a further period of five years.

The agreement as amended was adopted, and it was resolved on the motion of Dr. George Bell, seconded by Dr. W. F. Simmons, that the agreement should be submitted to the Australasian Medical Publishing Company Limited for approval.

National Health and Medical Research Council.

The Federal Council had before it the report of the twelfth session of the National Health and Medical Research Council held at Canberra on November 26 and 27, 1941. The report, which dealt with a salaried medical service, was published in THE MEDICAL JOURNAL OF AUSTRALIA of December 20, 1941, at page 710. Some correspondence was read to the members of the Federal Council in regard to the instructions to be given to the representative of the Federal Council on the National Health and Medical Research Council. A letter was also read from the Western Australian Branch addressed to the President of the Federal Council in regard to the representation of the Federal Council on the National Health and Medical Research Council. The Western Australian Branch expressed the view that the present representative had not the unanimous confidence of the Branches. The President said that the Director-General of Medical Services, Major-General S. R. Burston, had informed him that he was very anxious that some scheme of post-war reconstruction of the profession should be devised before the end of the war. In the President's opinion this should be done. The President also reported that Sir Alan Newton had told him that the Royal Australasian College of Surgeons intended to leave all medico-political matters in the hands of the Federal Council. It was therefore important that the Federal Council should elaborate a scheme for submission to the Federal Government after the war. Whatever happened, the profession should not be divided.

Dr. W. F. Simmons asked whether the Victorian Branch Council had gone further with the draft of a salaried service which was submitted to the last meeting of the Federal Council. This scheme was published in full in THE MEDICAL JOURNAL OF AUSTRALIA of December 13, 1941, at page 682. When it was presented to the last meeting of the Federal Council, the Victorian representatives explained that the scheme had been drawn up by a subcommittee of the Victorian Branch Council and had not been considered or adopted by the Council as a whole.

In reply to Dr. Simmons, Dr. H. C. Colville replied that the Victorian Branch Council had gone no further in the matter. He expressed the view, however, that the correspondence which had just been read and the views of the President showed that the Federal Council would have to consider a full salaried service. Dr. Colville also said that he wished to dissociate himself from any remarks that had been made about Dr. J. Newman Morris not having the confidence of all the Branches. He insisted that Dr. Newman Morris had always represented the views of the Federal Council on the National Health and Medical Research Council. He had always done what he was elected

to do. Such considerations were, however, ancient history. What the Federal Council had to do there and then was to make up its mind what its course of action would be. The Federal Council had received a letter from the Minister of Health of the Commonwealth stating that no scheme such as that drafted by the National Health and Medical Research Council would be instituted before the end of the war. The Commonwealth Government was thinking seriously of the matter, and while it would prepare a scheme, it would not take any steps towards implementing it until the war was over. It therefore behoved the medical profession to express its views and to mould the mind of the Federal Government, so that any scheme eventually put forward would be acceptable to the profession. It was known that certain activities had been instituted by at least one influential member of the Royal Australasian College of Physicians; steps had been taken to inform the Federal Government on certain aspects of a salaried medical service. If the profession did nothing a split was likely to occur. Dr. Colville therefore declared that the Federal Council must make some attempt to help the profession as a whole to achieve unity and to speak with a uniform voice. It could do nothing more valuable than this. He therefore moved as follows:

> That the Federal Council move for a conference between the Federal Council and representatives of the Royal Australasian College of Physicians and the Royal Australasian College of Surgeons to consider the future of medical practice with particular emphasis on the subject of a salaried medical service.

The motion was seconded by Dr. George Bell.

Dr. C. Craig agreed with Dr. Colville, but did not think that emphasis should be laid on the question of a salaried service. Speaking for himself, he said that there was a time when he did not want a salaried service, but his views had changed. Dr. F. L. Davies said that particular mention was made of a salaried service because the Royal Australasian College of Physicians was at that time considering the report of the National Health and Medical Research Council on a salaried service.

Dr. T. A. Price remarked that the Federal Council could not really be said to represent the views of the whole profession. Many different opinions were expressed, and it was obvious that the Federal Council itself was by no means unanimous. The general practitioners wanted specifically to be consulted. As far as Dr. Price could see, in any discussion that took place on a salaried service, the only unanimity which appeared on the surface was in regard to large salaries. Provided the salary was large enough, many members of the profession did not mind what form the service would take. This was to be deplored, and the general public should not be allowed to think that the whole profession took this attitude. What the public wanted was a good service first of all. Dr. Price thought it was quite right to consult the Royal Colleges; but it was also important that the medical profession should consult its patients. The Queensland Branch thought a conference should be held with trades unions, friendly societies, returned soldiers' organizations and so on. It thought that all the different schemes should be put before such a conference. The scheme should be explained to these people, and they should be asked what kind of a service they wished to have. Dr. Price was quite certain that they would not choose a salaried service. They would want to have free choice of their doctors. Dr. Price thought that the Branch representatives on the Federal Council should be asked to meet representatives of the bodies named by him in their several States. Principles and not details should be discussed. He thought that the politicians would tumble over themselves to do what the people wanted.

Dr. F. L. Davies thought that the Federal Council should work out the details of a salaried scheme, so that they would be available to put before any conferences that might be held. Dr. W. F. Simmons moved and Dr. A. F. Stokes seconded the following amendment:

> That the Federal Council move for a conference between the Federal Council and representatives of the Royal Australasian College of Physicians and the Royal Australasian College of Surgeons to consider the future of medical practice.

Dr. A. E. Lee said that the Federal Council should also consider the present basis of practice to see if it could not ward off the danger of instituting changes. In his opinion only two schemes remained to be considered; these were the present type of medical practice and a salaried scheme. A scheme of services arranged on a capitation rate would be frankly impossible. Dr. Lee thought that an attempt should be made to follow the example of the American Medical Association and improve the present basis of private practice. The Federal Council might discuss what terms it would like if a salaried scheme was introduced, but it should not advocate such a scheme. The General Secretary pointed out that many of the views expressed had been included in the broadcast to Australia on the British Medical Association post-war plans by Dr. G. C. Anderson, Secretary of the Association in London.

Dr. George Bell thought that the Royal College of Physicians should be seen, and Dr. N. M. Cuthbert thought that both Colleges should be seen.

Dr. F. W. Carter said that one thing should have emerged from the correspondence that had been read, and that was the feeling of unrest among practitioners in Western Australia. It was essential that unanimity should be obtained. A scheme should be formulated which would be acceptable to the profession and to the Government. Dr. Carter thought that the members of the Association should be disciplined in such a way that the Federal Council was the only body which could speak, and others should remain silent.

On being put to the meeting, Dr. Simmons's amendment was carried.

A discussion then took place regarding the machinery for calling the conference, and it was resolved that the President of the Federal Council should invite the President of each Royal College or his deputy to the conference.

At this stage correspondence between the President and the Federal Minister for Health regarding deferment of any changes in medical service until after the war was read.

Representation of the Federal Council on the National Health and Medical Research Council.

Dr. T. A. Price raised the question of the representation of the Federal Council on the National Health and Medical Research Council. In the opinion of the Queensland Branch the Federal Council's representative should be a general practitioner member of the Federal Council. He therefore moved that the Branches be asked to give consideration to the question of the representative of the Federal Council of the British Medical Association in Australia on the National Health and Medical Research Council being a general practitioner member of the Federal Council.

The motion was seconded by Dr. A. E. Lee and carried.

General Medical Service for Australia.

The General Secretary drew attention to a talk that had been broadcast over the national network by the Australian Broadcasting Commission on September 12, 1942. The talk, which dealt with the British Medical Association's post-war plans, was given by Dr. G. C. Anderson, the Secretary of the Parent Association. The matter was noted.

Dr. T. A. Price drew attention to the Queensland Branch's request for a conference between the Federal Council and certain non-medical bodies. He moved:

> That the Federal Council be asked to arrange a conference with the Australian Council of Trade Unions, the Federal Consultative Committee of the Friendly Societies of Australia, the Federal Council of the Returned Sailors, Soldiers and Airmen's Imperial League of Australia to discuss a general medical service for Australia and that it be suggested by the Federal Council to the Branches that each Branch arrange a conference with similar bodies in their respective States.

The motion was seconded by Dr. A. E. Lee.

Dr. H. C. Colville expressed the opinion that there were several objections to this suggestion. He thought that the time was premature to discuss with lay bodies a matter about which the profession was not unanimous. Even if the profession was unanimous, he thought that the lay mind would find it difficult to appreciate the subtle differences in various schemes. The bodies mentioned in the motion did not represent the whole body of public opinion.

Dr. George Bell remarked that the medical profession did not know what it wanted. If it did know there would be something in Dr. Price's suggestion.

Dr. C. Craig agreed with Dr. Bell. The main objection was the profession's own lack of unanimity. The profession was deficient in that it lacked any propaganda sense.

The President said that he thought it would be a mistake to seek the views of other bodies, before the Federal Council was certain of its own views.

Dr. N. M. Cuthbert thought that there was a good deal in what Dr. Price had said. The only way to get at the politician was through the public, and the medical profession had to make some attempt to discover what the views of the public were. Dr. Cuthbert also referred to the repatriation aspect and the desirability of discovering the views of men returning to civil life from active service.

Dr. F. L. Davies said that the people who received services were in a position to say how those services were defective. For this reason, there was merit in Dr. Price's suggestions. If the medical profession were to get into touch with the poorer sections of the community, they would be able to tell the profession what they wanted. First of all, however, the profession's own views must be perfectly clear.

Dr. Price said that he had had experience with people of the type that he had mentioned. He knew that they were intelligent and would give their opinions.

The motion proposed by Dr. Price, on being put to the meeting, was carried.

Some discussion then took place on the time when these conferences should be held, and it was resolved on the motion of Dr. A. F. Stokes, seconded by Dr. W. F. Simmons, that the conferences should be arranged after the Federal Council had decided what schemes for a general medical service should be submitted.

Parliamentary Select Committee on Social Security.

The General Secretary reported that he had sent to the secretary of the Parliamentary Select Committee on Social Security copies of the Federal Council's scheme for a general medical service for Australia. He also reported that he had asked that no radical alterations be made before the end of the war. The correspondence was read and noted.

Report on Sociological Problems.

The General Secretary reported that he had received from the secretary of the Royal Australasian College of Physicians a copy of a report by Professor John Bostock on sociological problems. The report, which was published in THE MEDICAL JOURNAL OF AUSTRALIA of February 14, 1942, at page 208, was sent to the several Branches. The report was received.

The Contract Practice Committee.

The General Secretary referred to the Contract Practice Committee of the Federal Council. He reported that the nominations of the Branches were as follows: *New South Wales*, Dr. H. R. R. Grieve; *Queensland*, Dr. T. A. Price; *South Australia*, Dr. R. J. Verco; *Tasmania*, Dr. J. R. Robertson; *Victoria*, Dr. C. H. Dickson; *Western Australia*, Dr. M. K. Moss. The General Secretary also reported that in view of the lapse of time it would be necessary for the Branches again to nominate representatives.

Contract Practice.

Friendly Society Lodge Practice.

At the meeting of the Federal Council in September, 1941, reference was made to the Victorian lodge capitation rate. This matter arose out of a conference held between the Contract Practice Committee of the Federal Council and the Consultative Committee of the Friendly Societies of Australia. This conference considered the proposed Federal common form of agreement, and the decision that no further steps should be taken until certain adjustments had been made in the Victorian lodge capitation rate. The representatives of the Consultative Committee of the Friendly Societies who attended the conference had unanimously agreed that some adjustment should be made. Later on, however, the friendly societies in Victoria had refused to agree to any increase in the rate. At the September, 1941, meeting of the Federal Council, it was reported that someone had written to the Federal Prices Commissioner, and it was now reported that the Prices Commissioner had refused to agree to any increase, and had suggested that possibly an inquiry might be made by a member of the judiciary. The Victorian Branch had decided to go no further with the matter, and the Federal Council therefore came to the same decision.

The Extension of Contract Medical Practice.

The Federal Council had before it a memorandum from the New South Wales Branch dealing with the extension of contract practice to munition workers and employees of the Allied Works Council. The memorandum stated that the wartime establishment of munition factories in country towns in New South Wales had led to problems in regard to the provision of medical services which were not foreseen in peacetime. Large numbers of persons had moved from the city to these areas. A certain percentage of them—difficult to estimate—had been used to obtaining medical attention on a contract basis. It was only reasonable to assume that this same group would seek to obtain similar benefits in their new surroundings. Moreover, with large numbers of persons engaged in an industry in the one factory, it was only natural that they would tend to organize themselves for the purpose of obtaining mass benefits.

Medical services on a contract basis were likely to be, and in fact already were, one of the benefits sought. The employees of the munitions factory at Lithgow had been receiving this benefit, whilst requests for similar services had been made by the factories at Orange and Bathurst. Other industries were doing likewise—for example, the Australian Iron and Steel, Cadia via Orange. The steel works on the South Coast and various coalfields had for some years enjoyed the benefits of contract medical services, whilst within the last few years the Yanco Agricultural College, the Farrer Memorial Agricultural High School and the Teachers' College, Armidale, had either received or sought similar benefits.

War conditions had led to the division of the population into a number of groups, such as the various armed forces and the women's auxiliaries. The former, and some of the latter (for example, the Women's Auxiliary Australian Air Force), received medical attention free of charge. From day to day other groups were formed, the latest being the Civil Constructional Corps, Allied Works Council. All this grouping tended to medical services being rendered on an organized mass basis. If there was added to this change in the social organization, temporary though it might be, the demand on the part of many persons for a nationalized medical service, it was obvious that the profession must be prepared to meet the position. An extension of contract medical service would be the most reasonable solution.

If an efficient contract service could be provided to a moderately large section of the community, it might well be the means of preventing the establishment of a nationalized service. Any extension of services must involve consideration of (*a*) income limit, (*b*) scope of service, (*c*) rate of remuneration.

In regard to income limit, it was pointed out that during the war wages had risen considerably apart from any increase due to overtime. It might be argued therefore that there was no need for an extension of contract practice, but that on the other hand, the people would be better able to afford private fees. Such argument could be best answered by pointing to the altered social conditions now existing, in the way of the division of the population into groups, and the consequent demand which must arise for mass benefits. To allow the income limit to remain at its present level would have the following effects: (i) If adequately policed it would debar the entry of many persons as beneficiaries, and in fact would disentitle many present members from benefits. This would eventually be inimical to the interests of the profession in any fight against nationalization. (ii) If inadequately policed many with incomes in excess of the limit would gain entry to the scheme. At the same time it would be difficult to ask for any increase in capitation rates. As a basis on which to determine the income limit, the amounts agreed upon by the Federal Council in 1940 in the Federal Common Form of Agreement, namely, £312 to £364, should be accepted with an increase in these proportionate to the increase which had taken place in the basic wage since that date. Even on this basis there would probably be a large number of persons excluded from benefit owing to the great increase in wages within recent months. This position would be aggravated if wages due to overtime were taken into account.

In regard to scope of service, the Federal Common Form of Agreement might be used as a basis. Whilst many might argue that a complete service should be given, it could be stated with reasonable assurance that in the past the scope of service supplied in friendly society practice had proved satisfactory. Whilst it was true that the average person was unable to budget for illness, it was doubtful whether a complete 100% cover was justified. Sufficient cover should be given for the ordinary everyday illnesses with which people were affected. Outside these, the person had to look after himself. Whilst health and sickness were of national importance, the duty of the individual to look after himself was of equal national importance. Apart from any duty, it was a right, and one that should always be encouraged.

In regard to poor risks, a large percentage of the healthy young males had enlisted, leaving behind a more aged group. If these were admitted to benefits both the member and wife would be poorer risks. In regard to the children, some

of them might, of course, pass out of benefit, being over the age of sixteen years. On the other hand, with the increasing average age of those still under sixteen, the sickness rate would increase. There would also be a higher percentage of females during wartime with an increased sickness rate. In regard to loss of private practice, this would be impossible to determine without knowledge of the extent of the number of persons to be affected. Even with a known figure it would be difficult to determine with any accuracy the loss that would occur as a result of transfer from private to contract services.

In regard to medical examination, it had always been a condition of friendly society contract practice that a medical examination be made of each intending member.

After the memorandum of the New South Wales Branch had been read, it was resolved that the statements in the document regarding income limit to the scope of service, rate of remuneration and medical examination, should be considered separately.

A motion in regard to the income limit was proposed by Dr. W. F. Simmons and seconded by Dr. George Bell:

> That in any agreement for the provision of a general contract service, the income limit should be determined on the basis of the Federal Common Form of Agreement of 1940 and the then existing basic wage with an increase in its amount to meet the altered financial conditions, such increase to be in proportion to the percentage increase in the basic wage but not to include overtime.

Dr. F. W. Carter said that in the past contract practice had been regarded as a concessional service. The time had come when contract practice agreements should be made on a non-concessional basis. He objected to the waiving of overtime. The overtime was part of the income of the worker, and it was certainly true that the composition of the group whose service was under discussion was different from the usual lodge group. The contributors would be older and their health record would be not nearly so good as that of friendly society lodge patients. These people should have a medical service, but a more extensive service than a lodge service would be required. The effect of the inclusion of these people on the income of practitioners would be considerable. The added income on account of children, for example, would be lost. Dr. Carter favoured the omission of the initial examination. He suggested that if a man was able to work, it was sufficient indication that he might be accepted for a contract practice medical service. Even if there were among these persons some with chronic ailments, they should be included. They were to be regarded as incidents in the service to be rendered. Some workers would have gone from the metropolitan to country places. The whole family would not necessarily go, and as it was unlikely that two lots of rates would be paid, it would be necessary to adopt a per person or unit rate. This would penalize the man most in need of the service, the man with a large family. The whole subject was fraught with difficulties, and Dr. Carter hoped to see some light thrown on it.

Dr. W. F. Simmons at this stage pointed out that not only munition workers would be included in the service, but also employees of the Allied Works Council, and that these were to be found in every State. The problem was not peculiarly a New South Wales problem. Dr. Simmons pointed out that in Lithgow, New South Wales, the population had increased from 10 to 13 thousand to 25,000, and that of these only 5,000 were munition workers. The town of Lithgow had many problems. They were associated with the coal industry, the Railway Department and munitions. Dr. Simmons also referred to the increase in population of Orange and Bathurst. Dr. Simmons also explained the present arrangement in Lithgow in regard to attendance on munition workers.

The General Secretary said that if an income limit was retained, the rate had to be concessional. If the income limit was abolished, then it would be possible to have a non-concessional rate.

Dr. A. E. Lee said that the Queensland Branch had considered the matter and had adopted the view that there should be no income limit. The Branch also disagreed with a fixed rate. The rate had to be a unit rate and should vary with the risk rate of the particular group under consideration and other features. In regard to examination, the Queensland Branch thought that if the rate was fixed there should be an examination; if the rate was variable there should be no examination.

Dr. F. L. Davies said that the Victorian Branch had discussed the question of income limit, and that the proposal to have no income limit had been defeated. He thought that it was safe to continue with an income limit, but that overtime should be waived.

Dr. A. F. Stokes thought that an income limit should apply. He did not see how it would be possible to compute income if overtime were included.

Dr. T. A. Price said that the inclusion of an income limit was not a practicable possibility. It would also be unfair if there was a decent rate of payment.

Dr. George Bell said that the Federal Common Form of Agreement had been agreed to, and that it would be unwise in view of the war to depart from the principles on which it had been adopted.

Dr. A. F. Stokes said that the income limit in the Federal agreement was elastic.

Dr. W. F. Simmons's motion was then put to the meeting and carried.

In regard to the scope of the service, it was resolved on the motion of Dr. W. F. Simmons, seconded by Dr. H. C. Colville:

> That in any agreement for the provision of a contract service the scope of service should be that of the Federal Common Form of Agreement of 1940.

A discussion then took place on the question of remuneration.

In regard to the medical examination, Dr. Stokes said that he thought it would be a pity to waive the examination. If this was done, the next thing would be that the medical profession would find that a request would be made for the elimination of examination in all contract practice. It was his opinion that the inclusion of an examination would not result in the exclusion of many persons, because the standard would be lower than usual.

Dr. W. F. Simmons moved that the medical examination should be waived during wartime, and Dr. George Bell seconded the motion.

Dr. F. L. Davies supported Dr. Simmons. The proposed service was not comparable to lodge work, where examination served to protect the lodges. Dr. N. M. Cuthbert also spoke in favour of the waiving of the examination. Dr. Simmons's motion, on being put to the meeting, was carried.

Dr. N. M. Cuthbert asked what would happen if a man contributing to the service became chronically ill. To this Dr. Simmons replied that this was a point that should not be overlooked. A man who was ill in these circumstances received no pay, and he would therefore not contribute further to the service. The problem was not a simple one. As a rule a seriously ill person would be sent to hospital, where he would receive honorary medical service. When once the patient was sent to hospital, he would be lost to his own doctor.

National Health Insurance: The Press Publicity Committee.

Dr. George Bell and Dr. W. F. Simmons were reappointed members of the Publicity Committee of the Federal Council.

A Booklet on Preventive Medicine and the National Health.

The General Secretary reported that he had received copies of a booklet entitled "National Health Services and Preventive Methods for Improving National Health", by Dame Janet Campbell and H. M. Vernon. The booklet was published by the British Association for Labour Legislation. A copy had been supplied to each member of the Federal Council. The booklet was received and noted.

Alien Practitioners.

A letter was read from the Victorian Branch, asking for a definition of the word "alien" as applied to medical practitioners. The General Secretary reported that he had written to the Central Medical Coordination Committee and had received a reply to the effect that the term had not been defined. On the other hand the Committee had given the matter some consideration, and for the purposes of its deliberations had regarded an alien medical practitioner as any person who, by the laws of a country outside Australia, was qualified to practise medicine in that country. The reply was received.

The General Secretary also read a letter from the New South Wales Branch regarding a regulation issued some months previously dealing with alien doctors. The General Secretary pointed out that the latest regulations excluded all alien practitioners who were unregistered or unlicensed

from carrying out any medical practice at all. The wording of the regulation is as follows:

> . . . an alien, other than a registered medical practitioner, or a person licensed under these regulations, shall not,
>
> (*a*) "give or perform, for fee or reward, any medical or surgical service, attendance, operation, or advice;
>
> (*b*) advertise, or hold himself out, directly or indirectly, by any name . . . etc. or by any means whatsoever as being entitled or qualified, able or willing to practise medicine or surgery, in any one or more or all of its branches, or to give or perform any medical or surgical service, attendance, operation or advice".

The correspondence was received.

Admission of Alien Medical Practitioners to Membership of the British Medical Association.

The General Secretary read correspondence with the Branches regarding the admission of alien medical practitioners to membership of the British Medical Association. The Victorian Branch, he said, had a provision by which licensed alien practitioners could, if nominated, be elected as "provisional members". These members paid the same subscription as members of the Branch who were on active service. They were allowed to attend meetings, but had no vote. Their membership would cease when their licence terminated. It was also reported that letters had been received from the New South Wales Branch and the South Australian Branch, stating that they had no such provision. The correspondence was received.

The Sale of a Proprietary Antiseptic.

The General Secretary read some correspondence with the Queensland Branch and with the other Branches regarding the terms of sale imposed by the manufacturers of a proprietary antiseptic. The Queensland Branch reported that it had received a letter from the Pharmacy Board of Queensland, pointing out that under terms of sale a pharmacist was compelled to sell the proprietary antiseptic in certain original containers bearing the manufacturer's label. The pharmacist could not sell, even on the prescription of a medical practitioner, a smaller quantity than that issued in containers by the manufacturers. If he did so, he was guilty of breach of contract. The antiseptic had to be sold at a certain retail price, and no additional label could be attached. Moreover, a pharmacist could not sell the antiseptic to any other pharmacist who had been refused supplies by the manufacturers. Counsel's opinion had been taken, and this was to the effect that the manufacturers' conditions were binding. It was resolved, on the motion of Dr. F. W. Carter, seconded by Dr. N. M. Cuthbert, that representations should be made to the manufacturers, requesting the removal of the embargo on the sale of the proprietary antiseptic when prescribed in small quantities by medical practitioners.

War Emergency Organization.

Conditions of Service Committee.

The General Secretary pointed out that the Conditions of Service Committee of the Federal Council had to be appointed, as its term of office would shortly expire. On the motion of Dr. George Bell, seconded by Dr. A. F. Stokes, it was resolved that Dr. F. L. Davies and Dr. H. C. Colville should be reappointed members of the committee with power to coopt.

Repatriation Commission.

At its previous two meetings the Federal Council had discussed a request from the Repatriation Department for a medical service to be instituted for the benefit of wives, of orphans and of widowed mothers of men serving with the defence forces in the present war. The General Secretary reviewed the Council's previous discussions and the correspondence with the Minister. The Federal Council had approved of the establishment of a service as requested by the Department, and thought it should be run along the lines of the Federal Common Form of Agreement. At the same time it had agreed to waive the preliminary examination of persons to be included in the scheme. The Federal Council also decided that if all persons eligible for inclusion in the scheme were to be on the list, the rates should be 26s. *per annum* for those in metropolitan areas and 32s. for those in country areas. At the last meeting of the Federal Council it was resolved that the views of the Federal Council should again be brought before the Minister for Repatriation. It was also decided that in the event of an unfavourable reply being received, the offer to accept beneficiaries on lists for the service without examination should be withdrawn. The General Secretary reported that the views of the Council had been forwarded to the Minister, who had replied that he regretted that the terms were not to be the same as those of the 1914-1918 war, and he concluded that the Federal Council remained adamant on the subject. As the question had not been specifically mentioned, he asked whether he was to assume that there was no income limit for those proposed to be included in the scheme. He also asked whether he could assume that there would be no difficulty in the securing of attendance for these people. The General Secretary also said that a suggestion had been made that since the Repatriation Commission could not agree to supply a service to those who did not apply for it, some sort of time limit might be fixed. If persons applied to join the service after that time had expired, then an examination should be necessary. The General Secretary reported that he had forwarded the Minister's letter to the President, who had instructed him to send copies of it to Dr. H. C. Colville and Dr. F. L. Davies, members of the Conditions of Service Committee. Shortly after that the General Secretary had again written to the Minister and had pointed out to him that the income limit must apply; that an agreement should be drawn up between the Repatriation Department and the Federal Council; that though all members of the Association did not undertake contract practice, an effort would be made to persuade practitioners to undertake this work in the terms of such an agreement; that a flat rate of payment would have to be arranged; and that an interval should be fixed to enable those who wished to avail themselves of the facilities to join the service.

A reply had been received from the Minister, stating that he could not accept an income limit. The President had then asked the General Secretary to send the matter on to the Branches for their consideration. The Western Australian Branch had replied that it could not agree to the omission of an income limit. The Tasmanian Branch had replied that it would abide by the decision of the Federal Council. The South Australian Branch had agreed to waive the income limit, on condition that the concession should not be regarded as a precedent. The Victorian Branch thought that the proposal should be accepted and that if the rate was fixed at 26s. and 32s. the income limit might be waived. The Queensland Branch objected to the Federal Council dealing with a matter which was exclusively concerned with general practice. The New South Wales Branch supported the recommendation made by the Federal Council. Later on the Queensland Branch had written stating that some of the beneficiaries under this scheme were being put on the lodge lists of Branch members.

Dr. W. F. Simmons remarked that there should be an agreement with the Department, and the Federal Council then decided to consider the several points under discussion *seriatim*.

The question of income limit was first of all discussed. Dr. N. M. Cuthbert moved that the income limit should apply, and this motion was seconded by Dr. F. W. Carter.

Dr. F. L. Davies pointed out that the decision made on this item would determine whether an agreement was entered into or not. It was important that an agreement should be made. Members of the Council had to realize to whom the service would be given; it would be given to widows or orphans or both. These persons would be solely dependent on a repatriation pension and would be below the income limit. Even if there were a few whose incomes were too high, the income limit should be waived. Dr. Davies did not think that a decision to do this would be an embarrassment in future. As time went on the position would become easier. It was also important to remember the fact that the Repatriation Department was prepared to recognize the Federal Council as the body qualified to deal with this matter.

Dr. N. M. Cuthbert thought that the Federal Council should adhere to its decision. Dr. H. C. Colville supported Dr. Davies. He said that it would be unwise to insist on an income limit. Apart from the rights and wrongs of the matter, few persons would be affected, and even they would become fewer. It was very important that the Federal Council should be able to declare that it had made a genuine effort to provide a service for these people. Dr. Colville again warned the Federal Council that if they insisted on an income limit, the agreement would fall through altogether.

Dr. A. F. Stokes thought that the income limit should be waived. The number of people over the limit would be so few that they would not be worth considering. His experience after the last war was that not a single patient had been seen who was not entitled to the service.

Dr. C. Craig said that though the Federal Common Form of Agreement was to be the basis of the service, he was prepared to waive the income limit. Dr. A. E. Lee also agreed that there should be no income limit. The motion, on being put to the meeting, was lost.

It was then resolved on the motion of Dr. F. L. Davies, seconded by Dr. George Bell:

> That the agreement be between the Federal Council of the British Medical Association in Australia and the Repatriation Commission.

The question of the practitioners who would provide the service was then discussed. It was pointed out that the Federal Council could not agree that all members of the Association would undertake service under this agreement, since many of them did not engage in contract practice. It was therefore resolved on the motion of Dr. H. C. Colville, seconded by Dr. George Bell:

> That the Council reaffirms its decision to do all in its power to persuade every medical practitioner to give medical attendance to any beneficiary who may apply to him.

After the rate of remuneration had been further discussed, it was resolved on the motion of Dr. H. C. Colville, seconded by Dr. George Bell:

> That the rate be a flat rate, namely, 26s. in the metropolitan areas and 32s. in the country areas.

It was also resolved that a time limit should be set, during which beneficiaries might apply to secure service under the terms of the agreement. It was resolved on the motion of Dr. H. C. Colville, seconded by Dr. W. F. Simmons:

> That the time limit within which an eligible person may decide whether she wishes to avail herself of the medical benefits be not more than six months.

A Medical War Relief Fund (Great Britain).

The General Secretary reported that the total amount contributed to the Medical War Relief Fund (Great Britain) was £4,994 16s. 8d. This amount comprised the following donations from the several Branches:

	£	s.	d.
New South Wales	1,773	3	8
Queensland	234	9	0
South Australia	630	16	6
Tasmania	177	9	6
Victoria	1,757	3	0
Western Australia	421	15	0

The total amount received had been remitted to London.

The Classification of Public Hospitals into Essential and Non-Essential Groups.

At the last meeting of the Federal Council a discussion took place on the services rendered by public hospitals. This matter arose from a request by the General Secretary of the Parent Association for medical men to be sent from Australia to Great Britain. The Federal Council, on that occasion, adopted a resolution that the Central Medical Coordination Committee should be asked to consider the question of instituting a classification of the work of public hospitals into essential and non-essential services with a view to the possible necessity of curtailing the latter in the event of a national emergency. The General Secretary reported that no reply had been received from the Central Medical Coordination Committee on this matter, and he added that, since the last meeting of the Federal Council was held, the situation had changed in certain respects.

Dr. H. C. Colville again referred to the need for consideration of the classification of services given by public hospitals because of the demand that was being made by the armed Services for medical personnel. He stated that non-essential services were still being given at public hospitals; this was a peace-time service and the public expected it.

The President said that the Central Medical Coordination Committee would in all probability be considering the matter at a forthcoming meeting.

Dr. N. M. Cuthbert said that every medical practitioner was in the front line. He thought that the needs of the civilian population might be met if medical officers were seconded from the armed forces to do *locum tenens* work under certain urgent conditions. It was quite certain that if the fatigue of some medical practitioners was not dealt with, a breakdown in the services to civilians would occur.

Dr. A. F. Stokes said that it would do medical officers from the Services good if they could be put into private practices for a while.

Dr. W. F. Simmons thought that the discussion had got away from the original question of essential and non-essential hospital services. He was quite satisfied that much unnecessary hospital work was being done.

It was then resolved, on the motion of Dr. H. C. Colville, seconded by Dr. W. F. Simmons:

> That the decision of the Federal Council at its previous meeting be confirmed, namely, that the Central Medical Coordination Committee be asked by the Federal Council to consider the question of instituting a classification of the work of public hospitals into essential and non-essential services with a view to the possible necessity of curtailing the latter in the event of a national emergency.

Some further discussion took place on the establishment of a pool of *locum tenentes* from the armed Services. It was pointed out that in some towns in New South Wales the position was becoming urgent and that consideration had to be given to the normal wastage amongst medical practitioners. It was stated, for example, that about fifty doctors died every year in New South Wales. It was then resolved, on the motion of Dr. N. M. Cuthbert, seconded by Dr. A. F. Stokes:

> That the Federal Council write to the Central Medical Coordination Committee requesting that it immediately establish a pool of medical officers from all available sources of medical manpower.

The Examination of Recruits for Bodies Auxiliary to the Armed Forces.

The General Secretary read correspondence with the Branches regarding the examination of recruits for bodies which were auxiliary to the armed forces. Special reference was made to recruits to the Women's Land Army, and it was noted that a fee of 2s. 6d. had been suggested as suitable for examination of its recruits. It was reported that the South Australian Branch had inquired into the matter and had expressed the opinion that the examination should be carried out by medical officers of the Services. The Victorian Branch thought that the fee of 2s. 6d. was inadequate.

Dr. F. L. Davies said that the position was different when the individual was asked to pay a fee and not the Government, and he thought that it would be lowering standards if a fee of only 2s. 6d. were asked for a complete medical examination. He would prefer to charge no fee at all.

In this regard it was pointed out that it was the Department that would pay.

Dr. A. F. Stokes agreed with Dr. Davies's view. He said that recruits to the Voluntary Aid Detachment had to produce certificates, and that a fee of 10s. 6d. was paid for this examination. He agreed that he would prefer to carry out an examination without making a charge rather than ask a fee of 2s. 6d.

Dr. T. A. Price agreed that a fee of 2s. 6d. was not enough, and thought that 5s. might suffice if the Government paid. He thought that as these recruits would have to work hard, they should have a preliminary examination.

Dr. H. C. Colville moved and Dr. T. A. Price seconded a motion to the effect that the fee for examination of such auxiliary bodies should be 5s. and that the fee should be paid by the Government. This motion was lost, and the Federal Council then resolved, on the motion of Dr. A. F. Stokes, seconded by Dr. H. C. Colville:

> That the Federal Council is of opinion that such examination should be carried out by medical officers employed by the Government.

Request for Reduced Rates for Attendance on Members of the Women's Land Army.

The General Secretary read a letter forwarded to the New South Wales Branch from the Superintendent of the Women's Land Army, asking if the Association would approach its members with a view to the Women's Land Army personnel receiving attention at concessional rates. It was resolved, on the motion of Dr. C. Craig, seconded by Dr. W. F. Simmons, that a reply should be sent to the Superintendent of the Women's Land Army, pointing out that it was open to any member of the Women's Land Army to obtain medical benefits through a friendly society lodge.

The Long Hours of Munition Workers.

At its last meeting the Federal Council considered the hours worked by munition workers. On that occasion the General Secretary reported that the Prime Minister had replied that under existing conditions there was no alternative to the working of twelve hour shifts, and it was then resolved that a further letter should be written to the Prime Minister emphasizing the Federal Council's previous views.

The General Secretary reported that another letter had been sent to the Prime Minister, asking if it had been possible to ameliorate the conditions. The Prime Minister had replied that he was in full accord with the views expressed by the Federal Council, but that he could not do anything in the matter at present. The view was expressed that the Prime Minister's reply evaded the whole issue.

Dr. T. A. Price thought that the Federal Council's views should be pressed again. The Government was allowing long hours, not because it believed that the output was more, but because it hesitated to cut down overtime pay. There was in Dr. Price's opinion no doubt that accidents, absenteeism and low production were due to long hours of work.

After discussion it was resolved on the motion of Dr. W. F. Simmons, seconded by Dr. F. W. Carter, that a statement should be prepared by Dr. T. A. Price for submission to the Press.

The Rehabilitation of Returned Men from the Armed Forces.

A letter was received from the Queensland Branch, asking for details of the rehabilitation of men from the armed forces. The General Secretary reported that he had written to the Repatriation Department in New South Wales and had been informed that machinery existed for the placing of returned men in industry. Of those who returned in 1939, 860 men had been placed. Returned soldiers might obtain grants of a sum up to £10 for the purchase of tools of trade and loans up to £40. Dr. T. A. Price expressed the opinion that repatriation committees should be formed in local centres. This had been done during the 1914-1918 war with much success in several centres. It was then resolved, on the motion of Dr. George Bell, seconded by Dr. W. F. Simmons, that the General Secretary should write to the Minister for Repatriation and ask for further information.

The Protection of Practices.

Reference was made to the protection of practice schemes in operation throughout Australia and to the allowance as deductions for income tax purposes of sums contributed to such schemes. The General Secretary read some correspondence that had passed between the Royal Australasian College of Surgeons and the Federal Council, and pointed out that the Federal Government had taken steps to make contributions to these schemes allowable deductions.

Dr. F. W. Carter drew attention to the need for obtaining a ruling on the matter, because of the liability of taxation in respect of moneys collected to assist members of the profession on their return to civil life after the war. The fund in Western Australia, as he had mentioned earlier in the meeting, amounted to approximately £6,000, and was still in operation. At the present rate of taxation the amount of taxation payable on such a fund in the first year after the war would probably be 17s. 6d. in the pound.

National Security (Medical Coordination and Equipment) Regulations.

Reference was made to statutory rules gazetted under the National Security (Medical Coordination and Equipment) Regulations regarding the power to require medical practitioners to act as medical officers in citizen forces and also to the proclamation under which medical practitioners below the age of sixty years could be conscripted for service.

The General Secretary reported that he had received a letter from the Western Australian Branch disapproving of certain aspects of the regulations. The Western Australian Branch pointed out that the Emergency Medical Service, in so far as it dealt with treatment of the sick and injured resulting from enemy action and of evacuees from their home districts, met with the entire approval of the Branch Council. The willingness of Western Australian members to afford adequate assistance in time of national emergency was reflected in the State-wide organization of first-aid and hospital treatment centres accomplished during the past four or five months. (The Western Australian Branch letter was dated June 2, 1942.) The Western Australian Branch disapproved entirely of the conscription of medical practitioners for the purpose of staffing outback centres. The evident intention of the Government to solve the outback and borderline problem by the conscription of salaried medical officers whose earnings would be the property of the Crown should in the opinion of the Western Australian Branch Council meet with the unanimous disapproval of the profession. Such a course of action, it thought, was both unnecessary and undesirable, in that the object could be achieved by other means. The three possible means suggested by the Western Australian Branch were: (a) the employment of alien practitioners engaged on a regional basis and for a limited tenure; (b) the making of a Government guarantee of a gross income for the doctor in outback areas of £1,000 *per annum*; (c) the employment of graduates of not more than three years' standing as part of their post-graduate experience. Under the guarantee system a medical practitioner would be assured a living (gross) income and the fruits of his industry and skill would remain his. It should further be remembered that between doctor and patient the utmost elasticity regarding fees pertained, and sympathetic allowance was made for the patient's financial status, even to the extent of cancellation of indebtedness when payment would cause undue embarrassment. It thus followed that the Western Australian Branch could not view with equanimity a scheme in which collection of medical debts became a function of a State or Commonwealth Government department. The anxiety of the Western Australian Branch regarding this phase of the scheme was not lessened by a scale of fees which, while it penalized the individual unfortunate enough to require medical attention after certain hours, failed to recognize the justice of remitting amounts thus collected to the doctor who gave the service. In short, the doctor was being compelled to be on duty for twenty-four hours in the day and for seven days in the week for a grossly inadequate wage, with no overtime allowance and the Government collecting the fees. It was recognized that there were exceptional cases, in which the system had had to be accepted and applied. An example was found in the Aerial Medical Service of Northern Australia. In this service, however, there had been special considerations as to distances and location that had proved insurmountable by other means. It had also to be remembered that the Aerial Medical Service paid an adequate salary of £1,000 *per annum* net. The Western Australian Branch thought that the schedule of fees had been formulated on the assumption that the system of conscripting medical practitioners for outback areas would meet with the approval of the profession. It was the opinion of the Council that representations should immediately be made with a view to the deletion of this clause and the manning of outback areas in a manner more in keeping with the principles of the profession. Finally the Western Australian Branch again referred to the importance of complete information being in the hands of the State Councils at the earliest possible moment. It considered that only through the Federal Council could this be accomplished with an expedition sufficient to enable the Branches to express their views early enough to secure for them a voice in the management of their own affairs.

The Queensland Branch wrote that it was prepared to accept the measures suggested by the Western Australian Branch, but thought it could not agree with the suggestion that young men of under three years' standing should be sent to outback areas. The New South Wales Branch was in agreement with the suggestion that a sum of £1,000 should be paid as a guaranteed annual income. The Victorian Branch did not agree with the Western Australian views and the South Australian Branch wrote that the Western Australian letter had been received.

Dr. N. M. Cuthbert said that two matters should have been referred to the Federal Council before they were introduced; one was the conscription of the profession and the other was the introduction of a scale of fees.

Dr. F. L. Davies said that while the Association had two representatives on the Central Medical Coordination Committee, it was not possible for these representatives to report back to the Federal Council. The Council appointed them and must trust them to put forward its views.

Dr. N. M. Cuthbert said that in the opinion of the Western Australian Branch the regulations were derogatory to the profession. The value of a voluntary system was five times that of a conscripted system. The Western Australian Branch objected to the fact that men were to be sent to country towns on Army rates of pay. Why should a medical practitioner serving in a civil capacity be offered the pay, say, of a major? No other section of the community was treated in this way. He could not see that the compulsory

system would solve the problem. Dr. W. F. Simmons pointed out that in New South Wales certain towns in the outlying areas guaranteed the doctor's income, and this was a satisfactory arrangement.

Dr. F. W. Carter referred to the resolution that had been sent to the Prime Minister by the Federal Council at the beginning of the war, and said that the members of the Western Australian Branch were still willing, as they had been previously, to assist voluntarily in any possible way, but they objected to being conscripted. He reminded the Council that the Prime Minister had declared that class conscription would not be undertaken. The differential treatment meted out to doctors should not have taken place. If a tradesman was moved from his home area to work in another place, he received an increase in wages and not a decrease, as was to be offered to doctors. Dr. Carter also insisted that the problem of the outback medical service was not only a wartime problem but a peacetime problem as well. A guarantee of £1,000 *per annum* would assist in securing medical officers for these areas.

Dr. C. Craig said that some other States had viewed the matter differently. The provisions were for a sudden emergency, and the authorities in his opinion should have the powers conferred by the regulations.

Dr. George Bell pointed out that representatives nominated to the Central Medical Coordination Committee could not report to the Federal Council. An emergency did exist, and men in New South Wales were asking what their duty was. Dr. Bell thought that the description of pay for doctors in terms of Army rank was unfortunate. At the same time, the method was introduced in good faith, with the object that the sacrifice of men at home should be equal to that of men who had gone away.

Dr. F. L. Davies said that it had been said in Victoria that a coordinating body was necessary; practitioners had to be told what to do, and no method that could be devised would be perfect.

Dr. N. M. Cuthbert pointed out that the Western Australian Branch was not criticizing the formation of the Central Medical Coordination Committee. One of the main questions at issue was that of salary.

At this stage the President addressed the meeting. He said that Dr. J. Newman Morris and he recognized that they represented the Federal Council on the Central Medical Coordination Committee. They as representatives were entrusted to do their best for the profession throughout Australia, and they had acted in belief that they were doing their best. It was quite impossible for matters to be reported to the Federal Council, for the deliberations of the Committee were secret. Even matters considered by the State Medical Coordination Committees were secret. Members of such committees would be guilty of a breach of National Security Regulations if they disclosed information. The question of conscription had been fully debated by the Central Medical Coordination Committee, and at the end of the discussion he and Dr. Newman Morris had been asked how the profession in Australia would regard conscription. They had had no hesitation in saying that the profession would support it, and he still believed that conscription of the profession would have the approval of the majority of those members who wanted to do what was best to win the war. The question of country districts was a small part of the whole problem. What the committee had in mind was that it might be necessary to move some of the profession from one part to another. Compelling powers and not advising powers were necessary. It was absolutely necessary to use the medical manpower in the best way, and so conscription was introduced. Otherwise it would be impossible to move men to a point where they were most urgently and suddenly needed, as, for example, in an epidemic. On the question of pay, the President pointed out that the remuneration that the medical practitioner in the country would actually receive—namely, a major's pay—would be more than if he had a gross income of £1,000 a year; moreover, the medical practitioner would receive allowances for such things as instruments. Each case would be decided on its merits, and if any question of unjust treatment arose, the committee would make an investigation.

Dr. N. M. Cuthbert then thanked the President for his explanation and for having allowed the discussion to take place.

The following motion, proposed *pro forma* by Dr. George Bell and seconded by Dr. W. F. Simmons, was withdrawn:

> That the Government be approached with a request that the Federal Council should have increased representation on the Central Medical Coordination Committee.

Dr. A. E. Lee then moved:

> That the Federal Council approach the Federal Government with a request that the scope of the Central and State Medical Coordination Committees be enlarged to include recommendations or advice upon all matters affecting the efficiency of professional work in the Services, and that the Central and State Medical Coordination Committees be recognized as bodies to which any medical officer in the Services may apply in matters regarding the exercise of his professional duties without its being regarded as a breach of military discipline.

The motion was seconded by Dr. T. A. Price, and being put to the meeting was lost.

National Security (Radium Control) Regulations.

The General Secretary reported that he had received from the Director-General of Health of the Commonwealth a copy of the National Security (Radium Control) Regulations, as notified in the *Commonwealth of Australia Gazette* of February 11, 1942. These regulations were published in THE MEDICAL JOURNAL OF AUSTRALIA of March 7, 1942, at page 299. The regulations were noted.

National Security (Venereal Diseases and Contraceptives) Regulations.

The General Secretary drew attention to the National Security (Venereal Diseases and Contraceptives) Regulations issued on September 1, 1942. These regulations were published in THE MEDICAL JOURNAL OF AUSTRALIA on October 17, 1942, at page 367. The General Secretary reported that he had written to the Federal Minister for Health in regard to the position of a medical practitioner who carried out, under the provisions of the regulations, an examination of a person suspected of suffering from venereal disease. The regulations provided that such a person could be apprehended and brought for examination to a legally qualified medical practitioner at such time and place as the Chief Health Officer might direct. The regulations already provided that no action should lie against the Commonwealth or against any State officer in respect of any apprehension or detention in pursuance of the regulations. The General Secretary pointed out that there was no indemnity for a medical practitioner who carried out an examination of a suspected person. Unless the person to be examined gave his or her consent the practitioner making an examination would be liable to an action at law for assault. The Minister was therefore requested to bring in an amendment to the regulations that would protect the medical practitioner. The correspondence was noted and the General Secretary's actions were approved.

Attendance on Members of the Military Forces.

A letter was read from the Western Australian Branch regarding the attendance on members of the military forces by area medical officers. It was thought that if arrangements were made for attendance to be carried out by area medical officers at contract rates, it would take men from their own doctors. It was pointed out that the provisions held only in regard to the members of the Permanent Military Forces, who were few in number, that the patient in question could later on attend any doctor whom he wished, and that, in any case, the petrol shortage and the scarcity of general medical practitioners had to be considered. The correspondence was received.

The Protection of the Lists of Lodge Medical Officers on Active Service.

A letter was received from the Victorian Branch asking that the lists of lodge medical officers on active service should be frozen for the duration of the war. It was thought that this should apply to all lodge patients except those who moved from one district to another. The General Secretary reported that he had sent a copy of the Victorian letter to the several Branches. The Queensland Branch had replied that it did not think such an arrangement was possible, but that it had been agreed that those concerned would act in the spirit of such an undertaking. The New South Wales Branch replied that action had already been taken along the lines indicated. The South Australian Branch saw no objection to such a provision and the Western Australian Branch thought that lists should be kept intact. The correspondence was received.

Petrol Rationing and Producer-Gas Units.

The General Secretary reported that a letter had been received from the Tasmanian Branch in regard to the inclusion of the cost of installing producer-gas units on motor cars as income tax deductions. It was pointed out to the Tasmanian Branch that the Tax Commissioners had ruled that the cost of the installation of producer-gas units on motor cars was not an allowable deduction. The cost was added to the cost of the vehicle and thus would be considered for deduction purposes in the computation of depreciation.

The General Secretary said that the New South Wales Branch was anxious to have the whole matter reconsidered, for it held the view that the installation of a producer-gas unit on a motor car depreciated the value of the car. Dr. W. F. Simmons said that the carriers in New South Wales had taken the matter up without success. He added, however, that Dr. Hugh Hunter had put forward what Dr. Simmons thought was a pertinent suggestion, namely, that the producer-gas unit might be considered from the point of view of fuel, and in this way its cost might be accepted as a deduction.

After further discussion it was resolved on the motion of Dr. W. F. Simmons, seconded by Dr. George Bell, that the General Secretary should be instructed to take up the matter again with the Commissioner of Taxation.

The Difficulty in Obtaining Motor Car Tires and Spare Parts.

The General Secretary read some correspondence with the Branches and with the Department of Supply and Development and the Director of Mechanization. It had been pointed out that the ranks of the medical profession had been seriously depleted, and that those who remained had very much more work to do than previously. In order that medical practitioners might be able to fulfil their obligations, motor cars in good working order had to be available to them. According to the regulations, it was necessary to apply to Melbourne for tires, tubes and other spare parts. This would take up far too much time for those living in distant parts. The Department had agreed to make facilities available for the supply of parts to medical men, and if necessary orders would be issued for this purpose. The correspondence was received.

Economy in the Use of Drugs.

The General Secretary reported that at the request of the Chairman of the Medical Equipment Control Committee a letter had been written to all members of the Association in Australia regarding economy in the use of drugs. The cost of this circularization had been borne by the Federal Council. The action was confirmed.

The Treatment of Rape and Indecent Assault on Females.

The General Secretary reported the correspondence between the Branches, the President and the Editor of THE MEDICAL JOURNAL OF AUSTRALIA on a letter received from the New South Wales Branch regarding the treatment of rape and indecent assault on females. It was noted that the letters had been published in THE MEDICAL JOURNAL OF AUSTRALIA of September 12, 1942.

The Employees of Medical Practitioners.

The General Secretary reported that the Victorian Branch had sent a copy of a resolution, in which it was proposed that a request should be made to the manpower authorities that employees in the consulting rooms of medical practitioners should be regarded as belonging to a protected industry. It was pointed out that many general practitioners had their consulting rooms in their homes, and that a great deal of time was required to attend to telephone calls and consulting room inquiries. Some practitioners had found it quite impossible to obtain help, and indeed one practitioner with a large practice had been compelled to state that unless he could get help he would have to confine his medical work to what he could undertake in the consulting room in his own home. The matter had been discussed with the Director-General of Manpower, who had been sympathetic. The Director-General stated that it was impracticable to regard such employment as a protected industry. It was necessary that all employees for work in doctors' homes should be engaged through the manpower office; but the authorities had promised to place doctors high on the list of those who would receive priorities.

Reference was made to the transfer of nurses employed in doctors' consulting rooms, and it was stated that such transfer had been carried out in one capital city. Dr. George Bell suggested that the matter should be brought before the Central Medical Coordination Committee, which in any case would be considering the employment of nurses throughout the Commonwealth.

Clothes Rationing for Pregnant Women.

The General Secretary reported correspondence which had taken place with the Minister for War Organization of Industry regarding the question of clothes rationing for pregnant women. It was pointed out to the Minister that in England pregnant women had been overlooked when clothes rationing was introduced, and the Federal Council would be glad to hear that it had not been overlooked in Australia. The Minister for Trade and Customs had replied that the position of pregnant women had been considered, and that 150 coupons would be issued after the fourth month of pregnancy on the completion of a request form, which would have to be accompanied by a certificate from a medical practitioner.

Doctors' Coats and Surgeons' Trousers.

The General Secretary reported that a paragraph had been published in *The Sydney Morning Herald* to the effect that doctors' coats and surgeons' trousers were to be supplied at a reduced coupon rate if application was made through the State Branches of the British Medical Association. The Rationing Commission had been communicated with, and a reply had been received to the effect that something of the sort was under consideration. Since that time many requests had been made to the Commission for further details, but no satisfactory reply had been obtained.

Paper Shortage and Advertising Literature.

The Queensland Branch drew attention to a letter which appeared in THE MEDICAL JOURNAL OF AUSTRALIA of July 25, 1942, from two medical practitioners, drawing attention to the plethora of advertising literature circulating among medical practitioners. In the discussion it was stated that many practitioners had received more than one circular in the same mail from the one firm, and it was held that this was not in keeping with the need for economy in the use of paper. It was finally pointed out that with recent restrictions that had been imposed on the use of paper, the abuse would probably disappear.

Medical Officers of the Armed Services of the United States of America in Australia.

The General Secretary reported that the Victorian Branch had offered the facilities of their Branch to the doctors of the armed Services of the United States of America serving in Australia, and the other Branches had also been informed of the offer, and similar steps had been taken in all States. The New South Wales Branch had suggested that copies of THE MEDICAL JOURNAL OF AUSTRALIA should be made available to United States Service doctors. The General Secretary read correspondence which had passed between himself, the President and the Australasian Medical Publishing Company Limited. In the last-mentioned letter he was informed that arrangements had been made for the supply of one copy of THE MEDICAL JOURNAL OF AUSTRALIA to each medical unit of the United States Army in Australia.

Diet in Wartime.

The General Secretary reported that he had received from Dr. Ivan Maxwell, of Victoria, a copy of a leaflet, which it was proposed should be issued by the National Nutrition Committee for distribution to the general public by medical practitioners in the course of their practice. The leaflet contained advice on how to keep fit by adjustment of the diet. It was couched in general terms, and approval was given by the Federal Council to its being issued by medical practitioners.

During the discussion attention was drawn to the valuable broadcasts given every day across the national network under the title of "The Kitchen Front".

Matters Deferred.

At the previous meeting of the Federal Council consideration had been given to a Federal Emergency (Compensation) Fund, to the public medical services, to the revision of the Federal Council's code of ethics and to the organization of the medical profession, and in all four instances consideration was deferred. Short reference was again made to each of these matters, and it was thought that the time was not opportune for their full discussion. Consideration was again deferred.

Consideration of a General Medical Service on a Salaried Basis.

The President drew attention to the fact that at the previous meeting of the Federal Council detailed consideration had been given to a scheme of general medical service for Australia drafted by a subcommittee of the Council. This scheme was one in which certain members of the community, whose income was below a stated figure, would receive medical service on a *per capita* basis. At the same meeting of the Council a scheme drawn up by a subcommittee of the Victorian Branch Council had been presented to the Federal Council. This scheme contained preliminary proposals for a salaried medical service. It had not been considered in detail by the Federal Council, because it had not received the approval of the Victorian Branch Council as a whole. The Victorian Branch scheme was published in THE MEDICAL JOURNAL OF AUSTRALIA of December 13, 1941, at page 682. Since the last meeting of the Federal Council the National Health and Medical Research Council had issued a detailed scheme for a salaried medical service. This scheme was published in THE MEDICAL JOURNAL OF AUSTRALIA of December 20, 1941, at page 710. The President thought that it would be a great mistake for the present meeting of the Federal Council to conclude without detailed consideration being given to both schemes. The Council might not be in favour of a salaried scheme, but it should nevertheless consider such a scheme, so that the members of the Council might be able to return to their Branch Councils and discuss it. If the Federal Council were at any future date to have a conference with the Government and to be asked "Have you considered a scheme for a salaried service?" it would not do if the Council had to reply in the negative. The next question asked of it would obviously be: "How can you advise on such a scheme if you have not considered one?" It was then resolved, on the motion of Dr. A. F. Stokes, seconded by Dr. W. F. Simmons, that the proposals of the Victorian Branch subcommittee for a salaried medical service should be considered.

At this stage Dr. H. C. Colville said that the Council had to take care that it did not get tangled in a mass of detail. Details did not matter; it was general principles which mattered. It was very easy to be lost in a mass of verbiage. He had made a brief summary of the main points of difference between the various schemes, and he had also summarized the points which they had in common. From this it appeared to him that there was not a great deal to be decided; only broad principles emerged.

There were three schemes, the Federal Council's own general medical service scheme, the scheme of the National Health and Medical Research Council for a salaried medical service and the scheme of the Victorian Branch subcommittee for a salaried medical service. He found on going through the schemes that there were four points of similarity. These were: (*a*) a desire to give an improved medical service to the community; (*b*) the establishment of hospitals and local clinics as centres for medical service; (*c*) the availability of such centres to all classes of the community; (*d*) the removal of certain disabilities under which the medical profession at present laboured. The last-mentioned point did not call for immediate discussion. Dr. Colville then went on to point out how the schemes differed. The Federal Council's scheme provided for a limited service—it was restricted to people whose incomes were below £416 *per annum*, and for these members of the community the scheme was to be compulsory. Outside these limits private practice was to continue. Within the scheme patients were to have free choice of doctor, but no mention was made of payment for services. The only policy laid down was to be found in a resolution passed by the Federal Council, namely: "That in the opinion of the Federal Council payment for the scheme should be on a *per capita* basis."

The National Health and Medical Research Council's scheme had some points in common with that drawn up by the Federal Council. Its outstanding features were: (*a*) The scheme was devised for all members of the community. (*b*) It would not abolish private practice, which the scheme stated should and would continue. (*c*) Payment to medical officers would be by salary.

The following were the important points about the Victorian scheme: (*a*) It was to be available to everyone in the community. (*b*) The payment of medical officers was to be by salary. (*c*) Private practice would be entirely eliminated. (*d*) It embodied the control of all members of the profession, not only after but before graduation, and the entry of students into their first year at the University was the time at which they would enter the scheme, their fees being paid by the scheme. (*e*) It embodied the principle of gradual promotion of medical practitioners for their services, with corresponding salaries as they attained seniority and professional skill.

One important point which had to be considered was whether the limited scope of the Federal Council's scheme was to be retained—in other words, whether the income limit proviso should stand. With the income limit clause the rest of the community remained outside the scheme, and this allowed present conditions of practice to continue. None of the other schemes had arrangements of this kind. The National Health and Medical Research Council's scheme allowed for private practice, but this private practice would be very much curtailed. The second great question was one of payment. Was payment to be by salary or on a *per capita* basis? Dr. Colville submitted that it was still possible for the Federal Council to retain its present scheme and yet alter the method of payment. There was nothing in any general medical service that demanded a *per capita* payment. A *per capita* payment laid great stress on the free choice of doctor, and Dr. Colville could not envisage a salaried scheme which would give the patient free choice of doctor.

The President thanked Dr. Colville for his thoughtful statement, and said that the Federal Council was indebted to him. He also pointed out that the National Health and Medical Research Council's scheme had failed to appreciate the value of the denominational system of hospitals.

Dr. A. E. Lee said that the Federal Council had to consider what were the defects of the present system, and with this Dr. C. Craig agreed. Thereupon the President drew attention to the first section of the Federal Council's scheme as published in THE MEDICAL JOURNAL OF AUSTRALIA of November 1, 1941, pointing out that the defects of the present system were very clearly stated in that document.

Dr. C. Craig said that the Federal Council's scheme left untouched the person who was just above the wage limit and could not afford to have every necessary investigation carried out. Dr. F. L. Davies said that Dr. Colville had raised this point, and he asked what would happen to a person just outside the income limit. Dr. W. F. Simmons said that presumably these persons would be treated in hospitals, which would be divided into public, intermediate and private sections. Dr. F. L. Davies then said that it should not be possible for a man to be crippled financially owing to a long illness.

The President then asked whether the service was to be on a concessional basis or not. It was his opinion that the Government would object to the inclusion of an income limit.

Dr. T. A. Price said that the service should be complete. One fault of the panel practice was that it was a cheap service. He wanted to see everyone with a good medical service. People should not be called upon to pay their last penny for the illness of a relative, and this would not be necessary if a proper form of group practice was introduced.

At this point the Federal Council decided to consider the Victorian subcommittee's scheme clause by clause. This was done, not with a view to making amendments, but with the object of offering criticism.

Some discussion took place around the statement in the first section of the report that general practitioners were excluded from the practice of preventive medicine. Dr. A. F. Stokes said that general practitioners did engage in preventive medicine, and Dr. N. M. Cuthbert agreed. Dr. C. Craig said that there was no plan of preventive medicine in general practice, though general practitioners had been able to achieve something. Dr. Craig thought that much more could be done by those whose whole time was given to it. Dr. W. F. Simmons pointed out that much had been done in New South Wales, and referred to the mass radiological examination of chests. At the same time Dr. Simmons was not satisfied with the liaison between health departments and the practising members of the profession. Dr. F. L. Davies said that in Victoria a great deal of the practice of preventive medicine was taken out of the hands of practitioners by baby health centres. Dr. A. E. Lee said that if the liaison failed, it was because of the failure of departmental medical personnel. He could not see that an improvement would take place if an extension of salaried service occurred. Dr. H. C. Colville pointed out that in the Federal Council's scheme a page and a half were devoted to the subject, and this was no doubt due to the fact that the Federal Council was not satisfied with the present liaison. Dr. Colville agreed that all practitioners should have an opportunity of practising preventive medicine. It was then suggested as an amendment that the statement of the scheme should read as follows:

That general practitioners should have greater opportunities for the practice of preventive medicine, and there should be more complete liaison between general medical practitioners and public health departments.

Some discussion took place regarding the movement of personnel as set out in clause 8 of the section dealing with control. The General Secretary pointed out that if seniority alone was to determine what movements should occur, a decision of regional committees might be sufficient. On the other hand, if professional attainments were considered, there should be some method of appeal against movement orders. Dr. T. A. Price said that a man should take root in a district and become a force there. If he was sent from one place to another after short intervals of service, his efficiency in practice would deteriorate. Dr. F. W. Carter thought that the hazards of private practice appealed to many practitioners. Dr. Price said that he thought the whole thing was autocratic, but Dr. H. C. Colville replied that the Council was trying to make the best of something it did not like. The General Secretary said that there must be promotion and there must be movement. Dr. T. A. Price did not agree with regard to movement, and thought that local control could deal with questions of promotion and pay. Dr. C. Craig said that there might be too much movement, and that continuity of residence in a place was necessary if good clinical work was to be done. Dr. H. C. Colville agreed that movement should be as little as possible. It was decided to add to the clause a statement that movement of personnel should not prejudice the efficiency of the service.

In the section dealing with regional organization, the Federal Council did not agree that personal contact with patients could be preserved and that a very considerable degree of freedom of choice of doctor would be available. The Council thought that the degree of freedom of choice would be limited.

In section 5, dealing with personnel, the Federal Council thought that the statement in paragraph 4 dealing with the salary to be paid to medical officers when they reached the age of twenty-eight years could be described as "adequate for their ability and experience".

The last sentence in the fifth and last paragraph of the same section contained the statement that the medical practitioner would retain his professional freedom of action and his personal relation with his patients. The Council thought that this sentence might be deleted.

The scheme drawn up by the National Health and Medical Research Council was then considered paragraph by paragraph, and various comments were made. It was resolved on the motion of Dr. W. F. Simmons, seconded by Dr. A. F. Stokes:

That the Victorian Branch's scheme for a salaried medical service and the National Health and Medical Research Council scheme for a salaried medical service be referred to Branch Councils for their comments and criticism, and that the reports of the Branch Councils be discussed at the next meeting of the Federal Council, so that the Council may be in a position to present its views to the Commonwealth authorities at the appropriate time.

At the request of the members, Dr. H. C. Colville agreed to prepare a statement setting out the main points of difference in the various schemes.

Death of Dr. Gregory Sprott.

Reference was made to the death of Dr. Gregory Sprott, who had been for twenty years a representative of the Tasmanian Branch on the Federal Committee and then on the Federal Council. It was resolved that a letter of condolence should be sent to his relatives.

Date and Place of the Next Meeting.

It was resolved that the date and place of the next meeting should be left in the hands of the President.

Votes of Thanks.

A vote of thanks was accorded to Sir Henry Newland for presiding. A vote of thanks was also accorded to the Council of the Victorian Branch and to Dr. H. C. Colville and Dr. F. L. Davies for their hospitality.

Correspondence.

POLYPOSIS WITH CLUBBING OF THE FINGERS.

SIR: In THE MEDICAL JOURNAL OF AUSTRALIA (Volume II, Number 13, September 26, 1942, page 308) you report some cases, one of which is by Dr. McLaren, a case of polyposis with clubbing of the fingers. I regret to see the remarks of Dr. Howard Williams, relative to the case, reported in such a manner that it appears to the reader that he (Dr. Williams) passed the sigmoidoscope up to the 20 centimetre mark before having a look, that is, with the obturator in the instrument. The method of passing the sigmoidoscope blind except to just within the anal canal is strictly against principles of proctology and surely Dr. Williams would be horrified did he realize that his remarks could be so interpreted.

Yours, etc.,

IAN HAMILTON,
Major, Australian Army Medical Corps.

October 29, 1942.

Naval, Military and Air Force.

CASUALTIES.

ACCORDING to the casualty list received on October 9, 1942, Major Stanley Liddelow Seymour, A.A.M.C., of Hyde Park, South Australia, is reported to have been killed in action.

According to the casualty list received on October 9, 1942, Captain Sandy Edwin John Robertson, A.A.M.C., of Bellevue Hill, Sydney, is now reported removed from the "seriously ill" list.

According to the casualty list received on November 6, 1942, Captain J. D. Morris, A.A.M.C., Oakleigh, Victoria, previously reported missing, is now reported missing, believed prisoner of war.

According to the casualty list received on November 6, 1942, Captain R. M. Haines is reported placed on and removed from the "seriously ill" list.

Australian Medical Board Proceedings.

NEW SOUTH WALES.

THE undermentioned have been registered, pursuant to the provisions of the *Medical Practitioners Act*, 1938-1939, of New South Wales, as duly qualified medical practitioners:

Dey, Robert Middleton, M.B., B.S., 1942 (Univ. Sydney), Royal North Shore Hospital, Saint Leonards.

Dobell-Brown, Noel Glenn, M.B., B.S., 1942 (Univ. Sydney), Marrickville and District Hospital, Marrickville.

Dunlop, Iain Buzzard, M.B., B.S., 1942 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.

Dunn, Richard Evelyn, M.B., B.S., 1942 (Univ. Sydney), Mater Misericordiæ Hospital, North Sydney.

Dwyer, Allan Frederick, M.B., B.S., 1942 (Univ. Sydney), Saint Vincent's Hospital, Darlinghurst.

Edye, John Andrew, M.B., B.S., 1942 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.

Ewart, Charles Colin, M.B., B.S., 1942 (Univ. Sydney), Sydney Hospital, Sydney.

Ferguson, David Alexander, M.B., B.S., 1942 (Univ. Sydney), Royal North Shore Hospital, Saint Leonards.

Fisher, Gerard Maxwell, M.B., B.S., 1942 (Univ. Sydney), District Hospital, Ryde.

Fotheringhame, Joan Marcelle, M.B., B.S., 1942 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.

Fowler, Noel Allison, M.B., B.S., 1942 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.

Frith, Alexander Richard, M.B., B.S., 1942 (Univ. Sydney), Sydney Hospital, Sydney.

Gallagher, John Paul, M.B., B.S., 1942 (Univ. Sydney), Lewisham Hospital, Lewisham.

Gibson, Edward William, M.B., B.S., 1942 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.
Goswell, George Basil, M.B., B.S., 1942 (Univ. Sydney), 33, Mary Street, Beecroft.
Gray, Helen Patricia, M.B., B.S., 1942 (Univ. Sydney), Brisbane General Hospital, Brisbane, Queensland.
Greenberg, Leslie Leonard, M.B., B.S., 1942 (Univ. Sydney), Sydney Hospital, Sydney.
Hardcastle, Philip Angus, M.B., B.S., 1942 (Univ. Sydney), Newcastle General Hospital, Newcastle.
Hemmingway, Clifford Kenneth, M.B., B.S., 1942 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.
Hemphill, Woodrow Sanford, M.B., B.S., 1942 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.
Henning, Richard Winston, M.B., B.S., 1942 (Univ. Sydney), Royal Hobart Hospital, Hobart, Tasmania.
Hercus, Victor Macky, M.B., B.S., 1942 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.

Obituary.

JOSEPH SMITH CLOWES.

WE regret to announce the death of Dr. Joseph Smith Clowes, which occurred on October 11, 1942, at Brisbane, Queensland.

GEORGE HENRY ABBOTT.

WE regret to announce the death of Dr. George Henry Abbott, which occurred on November 7, 1942, at Killara, New South Wales.

Nominations and Elections.

THE undermentioned have applied for election as members of the New South Wales Branch of the British Medical Association:

Fowler, Noel Allison, M.B., B.S., 1942 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.
Rundle, Philip Alan, M.B., B.S., 1941 (Univ. Sydney), 22, High Street, Newcastle.

Books Received.

"Towards Total War", by D. P. Copland; 1942. Sydney: Angus and Robertson, Limited. 7¼" × 5", pp. 49. Price: 2s.

"Medical Progress Annual", edited by Robert N. Nye, M.D.; Volume III; 1942. Springfield: Charles C. Thomas. London: Baillière, Tindall and Cox. 9" × 6", pp. 692. Price: $5.00, post paid.

"Practical Malaria Control", by Carl E. M. Gunther, M.D., B.S., D.T.M. (Sydney), with a foreword by Harvey Sutton, O.B.E., M.D., F.R.A.C.P., B.Sc., D.P.H., F.R.San.I.; 1942. Sydney: Consolidated Press, Limited. 7¼" × 5", pp. 91. Price: 6s. 6d.

"The Diabetic ABC War-time Supplement", by R. D. Lawrence, M.A., M.D., F.R.C.P. (London); Second Edition: 1942. London: H. K. Lewis and Company, Limited. 8¼" × 5¼", pp. 15. Price: 9d. net.

"The Health and Efficiency of Munition Workers", by H. M. Vernon, M.A., M.D.; 1940. Oxford University Press: London: Humphrey Milford. 9" × 5¼", pp. 146. Price: 15s.

"A Short History of Cardiology", by James B. Herrick; 1942. Springfield: Charles C. Thomas. London: Baillière, Tindall and Cox. 9" × 6", pp. 274, with 48 illustrations. Price: $3.50, post paid.

"The 1942 Year Book of Physical Therapy", edited by Richard Kovács, M.D.; 1942. Chicago: The Yearbook Publishers. 7¼" × 5", pp. 416, with illustrations. Price: $3.00.

"Facts for Childless Couples", by E. C. Hamblen, M.D.; First Edition: 1942. Springfield: Charles C. Thomas. London: Baillière, Tindall and Cox. 7¼" × 5", pp. 113, with illustrations. Price: $2.00, post paid.

"A Handbook of Allergy for Students and Practitioners", by Wyndham B. Blanton, M.A., M.D., Litt.D.; 1942. Springfield: Charles C. Thomas. London: Baillière, Tindall and Cox. 9" × 5¼", pp. 202, with illustrations, some of which are in colour. Price: $3.00, post paid.

Diary for the Month.

Nov. 17.—New South Wales Branch, B.M.A.: Ethics Committee.
Nov. 18.—Western Australian Branch, B.M.A.: Branch.
Nov. 19.—New South Wales Branch, B.M.A.: Clinical Meeting.
Nov. 24.—New South Wales Branch, B.M.A.: Medical Politics Committee.
Nov. 26.—South Australian Branch, B.M.A.: Branch.
Nov. 26.—New South Wales Branch, B.M.A.: Branch.
Nov. 27.—Tasmanian Branch, B.M.A.: Council.
Nov. 27.—Queensland Branch, B.M.A.: Council.
Dec. 1.—New South Wales Branch, B.M.A.: Executive and Finance Committee. Organization and Science Committee.
Dec. 2.—Western Australian Branch, B.M.A.: Council.
Dec. 3.—South Australian Branch, B.M.A.: Council.
Dec. 3.—New South Wales Branch, B.M.A.: Special Groups Committee.
Dec. 8.—New South Wales Branch, B.M.A.: Ethics Committee.
Dec. 8.—Tasmanian Branch, B.M.A.: Branch.
Dec. 10.—New South Wales Branch, B.M.A.: Branch.
Dec. 11.—Queensland Branch, B.M.A.: Annual Meeting.
Dec. 15.—New South Wales Branch, B.M.A.: Medical Politics Committee.
Dec. 18.—Queensland Branch, B.M.A.: Council.
Dec. 25.—Tasmanian Branch, B.M.A.: Council.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phœnix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia.

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